

Acute Abdomen

A plain-English guide for you and your family

WHAT IS HAPPENING

Your peritoneum is the smooth, slippery lining inside your belly that normally lets your organs slide past each other without pain. When your organs stretch or squeeze, you feel dull pain that is hard to pinpoint. But when the belly lining itself gets inflamed — from a hole in your gut, blocked blood flow that starves tissue, bleeding inside, a twisted blockage that cuts off blood, or infection — the pain suddenly changes to sharp and stays in one exact spot. Your belly muscles lock up tight to protect the area. Your heart races to make up for lost fluid or shock, then your blood pressure may drop. Your bowel stops moving because inflammation shuts down the normal squeeze waves. You lie perfectly still because any movement stretches the inflamed lining and causes agony — very different from a kidney stone patient who twists and turns in pain. None of this is random. Each sign is your body trying to survive the crisis by saving blood flow and stopping the inflammation from spreading. Reading the signs backward tells you the one broken thing upstream that started it all.

What you might feel

- Severe, sharp, localized abdominal pain
- Rebound tenderness (pain worse when examiner releases pressure)
- Involuntary guarding and rigidity (board-like abdomen)
- Absent or diminished bowel sounds
- A fast heart rate (Tachycardia) (heart rate greater than 100 beats per minute)
- Low blood pressure (Hypotension) (systolic blood pressure less than 90 mmHg) in severe cases
- Nausea and vomiting
- Patient lying motionless, knees drawn up
- Fever in cases of infection or perforation
- Distention (swollen belly) in obstruction or a stalled gut (ileus)

Call the doctor right away if...

- Low blood pressure (Hypotension) (systolic BP less than 90 mmHg) or signs of shock (cold, clammy skin, confusion, weak pulse)
- Rigid, board-like abdomen with severe rebound tenderness
- Pain out of proportion to physical exam findings (suggests mesenteric starved blood flow (ischemia)—blocked blood vessels feeding the bowel)
- Rising lactate (greater than 2 to 4 mmol/L) or worsening metabolic acidosis (acid building up in the blood) (acid buildup in blood from dying tissue)
- Free air on imaging (gas outside the gut seen on X-ray or CT, suggests perforation requiring emergent surgery)

What the care team will do

- Establish large-bore IV access (18-gauge or larger in both arms if possible) and start rapid fluid resuscitation with normal saline or lactated Ringer's—give 1 to 2 liters as fast as it will run, then reassess blood pressure and heart rate every 15 minutes.
- Keep the patient NPO (nothing by mouth—no food, no water, no ice chips) and place a nasogastric tube (NG tube—a tube through the nose into the stomach) to suction if bowel sounds are absent or the patient is vomiting repeatedly.
- Administer broad-spectrum IV antibiotics within 1 hour of recognition—common regimens include piperacillin-tazobactam 3.375 g every 6 hours or ceftriaxone 1 to 2 g every 24 hours plus metronidazole 500 mg every 8 hours.
- Monitor vital signs every 15 minutes initially—watch for worsening a fast heart rate (tachycardia) (heart rate above 100), low blood pressure (hypotension) (systolic BP below 90 mmHg), fever above 101°F, decreased urine output below 0.5 mL per kg per hour, or new confusion.
- Draw stat labs—complete blood count (CBC—counts red cells, white cells, platelets), comprehensive metabolic panel (CMP—checks kidney function, electrolytes, glucose), lactate (a waste product that rises when tissues lack oxygen), lipase (an enzyme that rises in pancreatitis), and blood cultures if fever is present.
- Position the patient with knees bent and head of bed elevated 30 degrees if blood pressure tolerates; avoid palpating (pressing on) the abdomen repeatedly.
- Prepare for emergency imaging (upright chest X-ray to look for free air under the diaphragm, or CT scan of the abdomen and pelvis with IV contrast) and notify the surgical team immediately—do not delay imaging to give pain medication.

- Reassess pain every 30 minutes using a 0-to-10 numeric scale and document location, quality, and any radiation; give IV opioids (such as morphine 2 to 4 mg or fentanyl 25 to 50 mcg) only after the surgeon has examined the patient, unless hospital protocol or surgeon preference allows earlier analgesia.

Medicines you may be given — and why

NPO (nothing by mouth) + IV fluids

When the belly is in trouble, we stop food and drink by mouth (NPO stands for 'nil per os,' Latin for 'nothing by mouth'). Why? Because the gut might need surgery soon, and an empty stomach is safer. Also, a sick or blocked gut cannot move food along properly. Instead, we drip balanced salt water (IV fluids) straight into a vein to keep the body hydrated, keep blood pressure steady, and replace fluid that leaked into the belly or was lost through vomiting.

Morphine or hydromorphone (opioid pain medicine)

Pain medicine does NOT hide the physical signs doctors find when they press on your belly. In fact, it helps doctors do a better exam. When pain is crushing, belly muscles clench tight (guarding), and the doctor cannot feel what is underneath. Pain medicine relaxes you and softens the guarding, so the doctor can feel masses, swelling, or the rock-hard belly that signals infection in the lining (peritonitis). Modern guidelines (from the American College of Emergency Physicians and others) say give pain medicine early—it makes the exam better, not worse.

Broad-spectrum antibiotics (e.g., piperacillin-tazobactam, ceftriaxone + metronidazole, or meropenem)

If doctors find signs of infection—such as a hole in the gut (perforation), dead tissue (ischemic bowel), infection of the belly lining (peritonitis), or germs in the blood (sepsis)—they give antibiotics that kill a wide range of bacteria. The belly normally holds trillions of bacteria in the gut; if those bacteria spill into the usually-sterile belly cavity or bloodstream, they cause life-threatening infection. Broad-spectrum means the antibiotic hits many types of bacteria at once (both the ones that need oxygen and the ones that live without it) until lab cultures identify the exact germ.

Nasogastric (NG) tube decompression

If the gut is blocked (bowel obstruction) or paralyzed (ileus), swallowed air, stomach acid, and fluid pile up and bloat the belly. This pressure causes pain, vomiting, and can even split the stomach or gut. A nasogastric tube is a thin plastic tube passed through the nose, down the throat, and into the stomach. We connect it to gentle suction to pull out the trapped fluid and

air. This lowers pressure, stops vomiting, and makes the person more comfortable while doctors plan surgery or wait to see if the blockage opens on its own.

Where this information comes from

- American College of Surgeons ATLS 10th edition
- Eastern Association for the Surgery of Trauma (EAST) Practice Management Guidelines
- World Society of Emergency Surgery (WSES) Guidelines 2017
- American College of Emergency Physicians (ACEP) Clinical Policy on Acute Abdominal Pain

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