

PROTOCOL FOR: Abdominal Pain (Nontraumatic)

POLICY: Patients with nontraumatic abdominal pain will have a focused assessment and diagnostics aimed at deriving a differential diagnosis with appropriate treatment plan.

DESIRED PATIENT

OUTCOMES: The patient will exhibit decreased severity of presenting signs and symptoms.

**CLINICAL
ASSESSMENT AND
CARE:**

1. Obtain history including onset, duration, location, type, severity, radiation, and associated signs/symptoms. In female patients, obtain gyn history (i.e., LMP, gravida).
2. Perform focused assessment, including inspection for distention, scars and masses; auscultation for bowel sounds and abnormal vascular sounds; palpate for tenderness, bruit, elicited pain response and rigidity. Re-assess as needed according to patient's acuity level.
3. Obtain vital signs, including orthostatics if indicated and evaluate pain using 0-10 or appropriate pain scale.
4. Keep patient NPO until MD indicates otherwise.
5. Consider life-threatening causes: abdominal aortic aneurysm, ectopic pregnancy, appendicitis, acute mesenteric infarct, GI bleed.
6. Insert IV and obtain blood work, as per MD order, i.e., CBC, CHEM7, LFTs, amylase, lipase.
7. Obtain other lab samples as ordered: i.e., UA, Hcg, stool culture.
8. Administer analgesics per MD.
9. Perform secondary assessment and re-assessments according to patient's acuity level, with vital signs and pain assessment as indicated (i.e. 30 - 60 minutes after administration of analgesic) and minimally every four hours.
10. Obtain x-rays per MD order and prepare for further diagnostics tests/exams (i.e., CT, ultrasound, gyn exam).
11. Administer other meds as ordered by MD (i.e., antiemetics and antibiotics).
12. Prepare for admission or OR intervention as deemed appropriate.
13. Obtain vital signs/ pain reassessment upon discharge/transfer from the ED.

**PATIENT AND
FAMILY**

- TEACHING:**
1. Explain all procedures to the patient/family.
 2. Keep patient/family informed of plan of care.

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3. Reinforce NPO status.
4. Review discharge instructions, per MD and medication reconciliation.

REPORTABLE

CONDITIONS: Worsening pain or abdominal swelling, blood in urine/stool/vomit/fever, hypotension or tachycardia which is a change from initial vital signs.

DOCUMENTATION: Document all vital signs, assessments, interventions and response to all interventions on ED record.

APPROVAL: Emergency Department Standards Committee
Nursing Standards Committee
Emergency Department Manager and Medical Director

EFFECTIVE DATE: 9/05

REVISION DATES: 8/08