

ED QUICK QUIZ

WHAT IS THE DIAGNOSIS?

Background

An 80 year old lady attends ED due to abdominal pain and diarrhoea.

This has been 'grumbling along' for several days, but since this morning she has had bloody diarrhoea and felt unwell. The pain is now 8/10, generalised, non- radiating and colicky.

PMHx: Type 2 D.M, HTN and peripheral vascular disease

Rx: Metformin (recently increased dose), Ramipril and Aspirin. She has NKDA

SHx: Lives alone, independent with ADLs, family assist with shopping. Smokes 15/day

O/E

Looks uncomfortable and a little clammy

RR 19 SpO2 96% HR 100 BP 100/60 Temp 37.5

Chest clear HS I+II+0

Abdomen is soft, diffusely tender with some guarding in the LUQ

Bloods are awaited but VBG is back:

H+ 50 Lact 4.5 otherwise NAD

Questions

1. What is the likely diagnosis?
2. What is the significance of the LUQ guarding

Answers & Discussion

1. What is the likely diagnosis?

Ischaemic colitis (aka ischaemic gut)

The patient's age, vascular risk factors and the combination of a relatively benign abdominal examination with elevated lactate should make you think of ischaemic colitis

2. What is the significance of the LUQ guarding?

The large bowel is supplied by both the superior mesenteric (SMA) and inferior mesenteric (IMA) arteries.

The rectum is supplied by both the IMA and internal iliac (AKA hypogastric) arteries.

These blood supplies overlap and have many collaterals; however there are two major 'watershed' areas, most distal to the supplying arteries, which are most vulnerable to ischaemia.

These are Griffiths' point at the splenic flexure, and Sudeck's point at the recto-sigmoid flexure

Ischaemia can occur due to thromboembolism or due to systemic haemodynamic instability. The mesenteric arteries are particularly sensitive to vasopressors, both innate and artificial, so the body's homeostatic attempts to preserve cerebral blood supply, and iatrogenic attempts to raise blood pressure e.g. due to sepsis could contribute to development of gut ischaemia.

There is no definitive diagnostic test, and it is mainly a diagnosis of exclusion e.g. diverticulitis, IBD or infective colitis/ gastroenteritis. CT may be suggestive and is usually performed depending on renal function and clinical suspicion.

Management is mostly supportive with fluids, analgesia +/- antibiotics. Depending on functional status and degree/ severity of bowel involved, the general surgeons may take the patient to theatre for laparotomy and resection.

