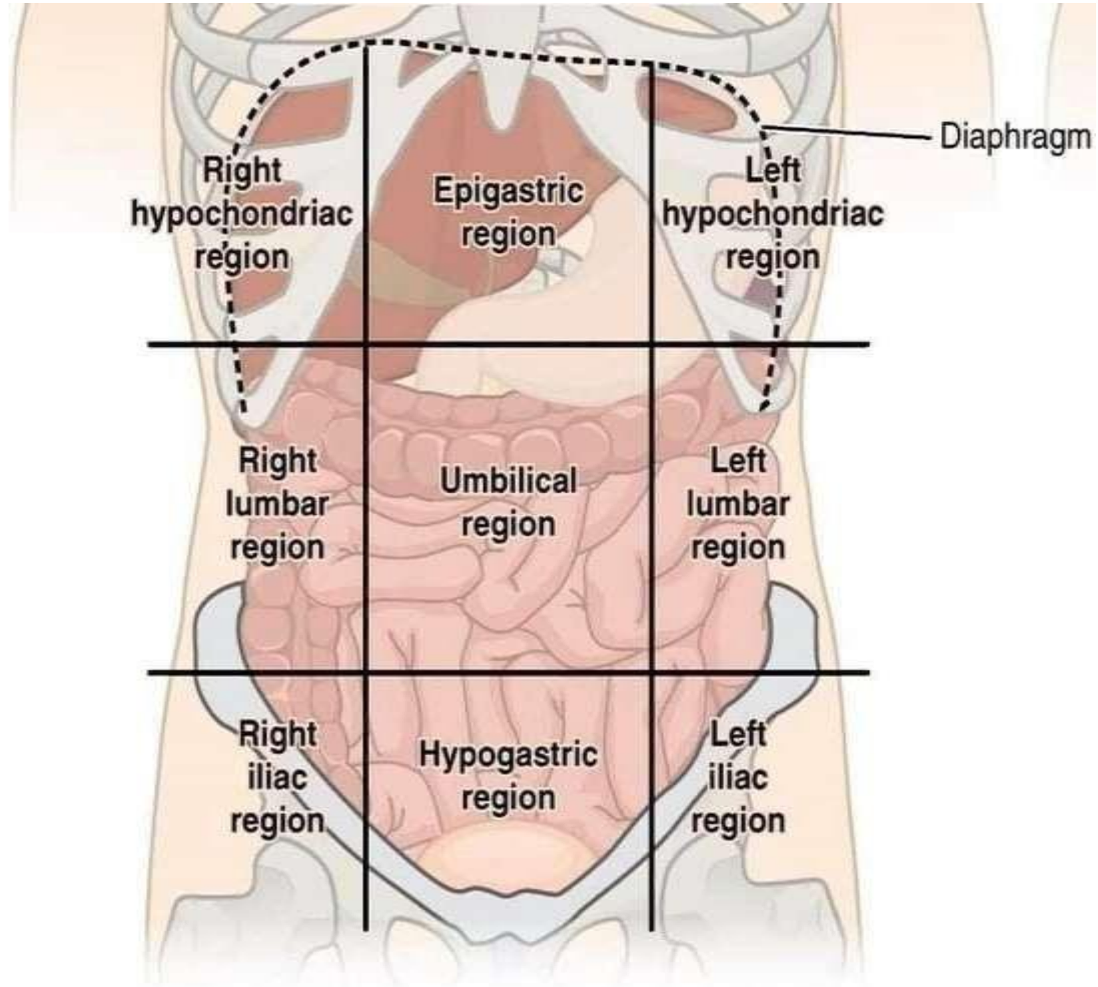
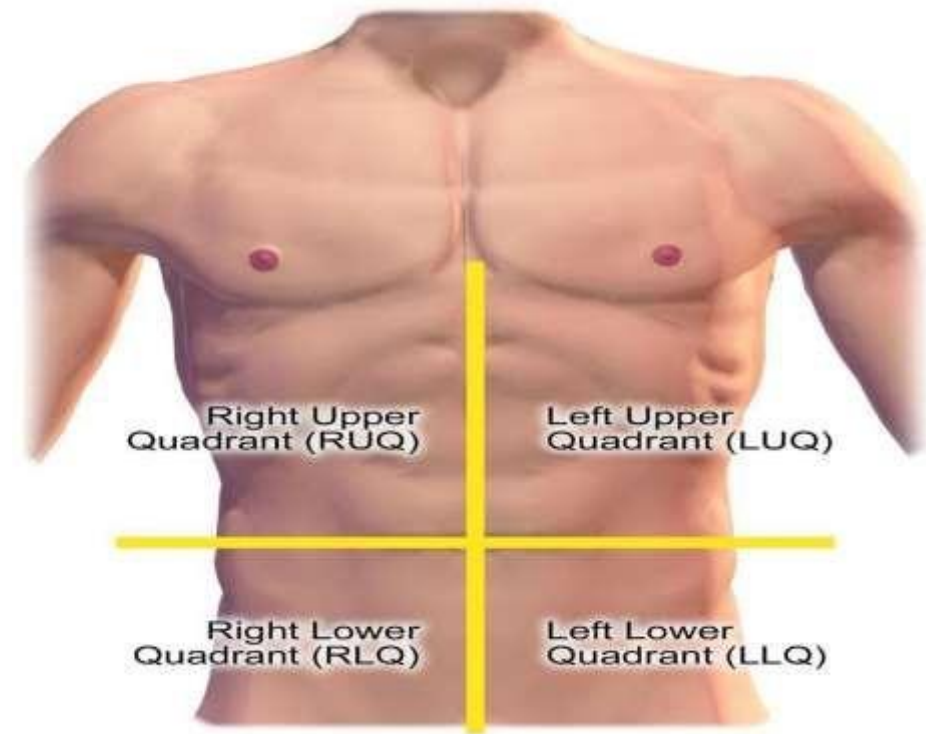
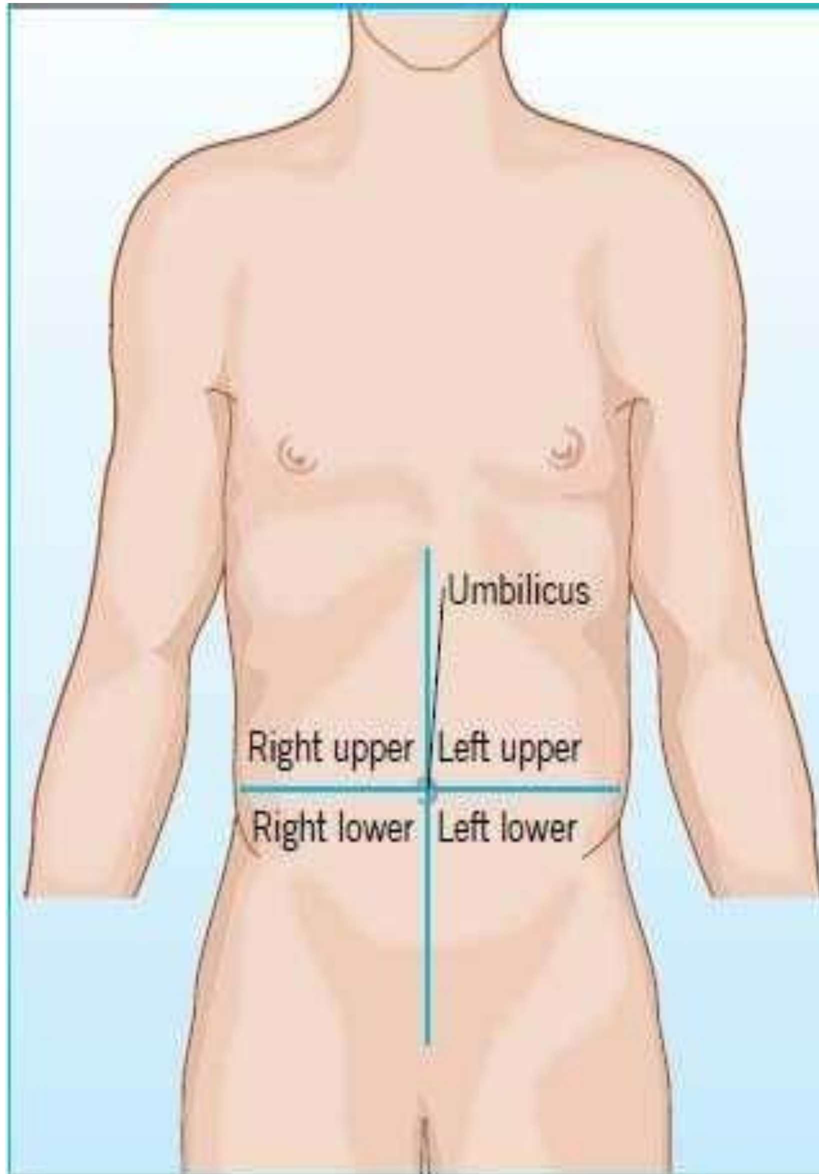
Abdominal assessment



(a) Abdominopelvic regions





Right upper

- Liver.
- Gallbladder.
- Duodenum.
- Head of pancreas.
- Right kidney and adrenal gland.
- Hepatic flexure of colon.
- Part of transverse and ascending colon.

Left upper

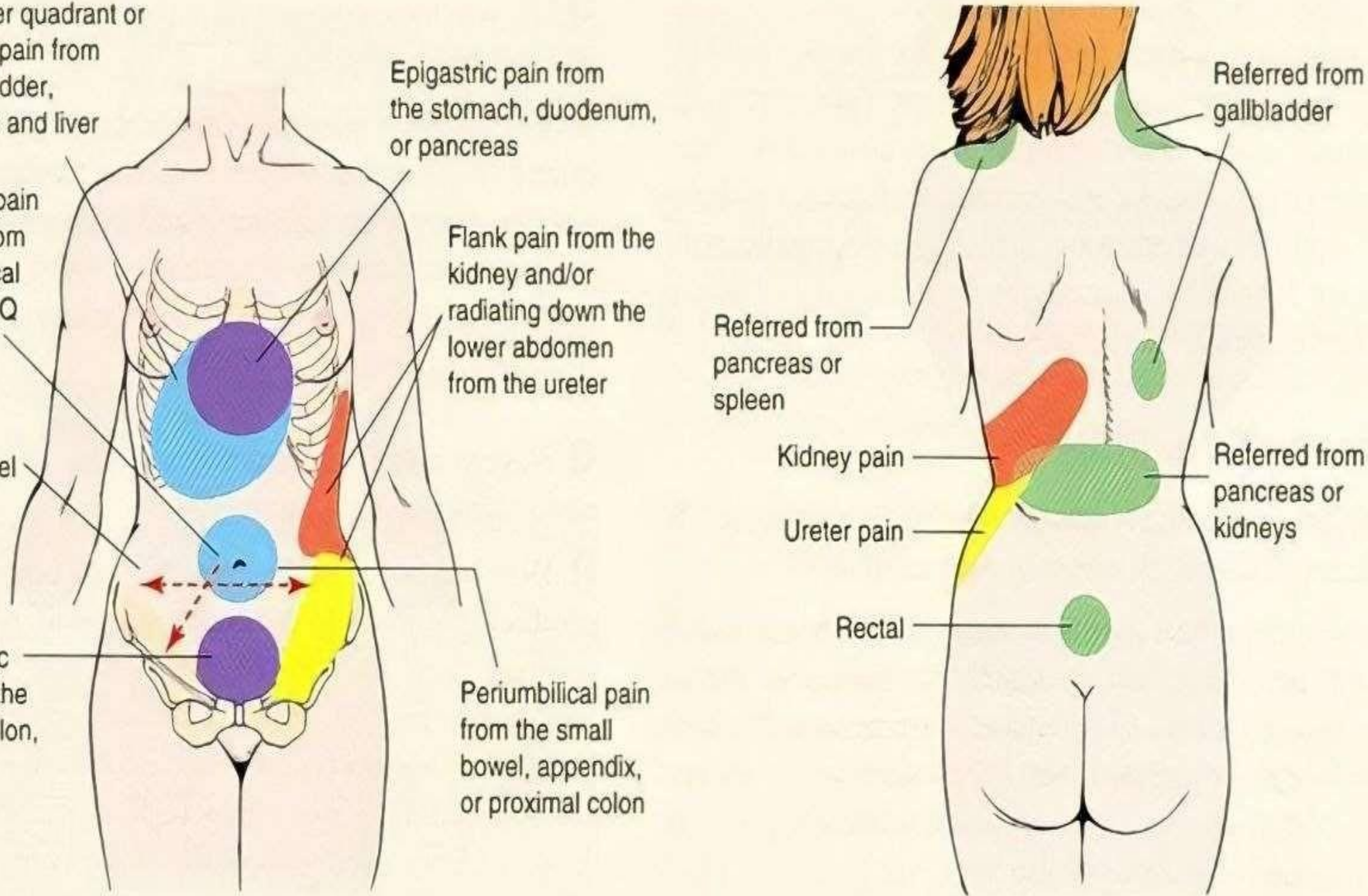
- Stomach.
- Spleen.
- Left lobe of liver.
- Body of pancreas.
- Left kidney and adrenal gland.
- Splenic flexure of colon.
- Parts of transverse and descending colon.

Right lower

- Caecum.
- Appendix.
- Right ovary and tube.
- Right ureter.

Left upper

- Part of descending colon.
- Sigmoid colon.
- Left ovary and tube.
- Left ureter.



Patterns and referents of abdominal pain.

Abdominal pain may be formally described as visceral parietal or referred

Items	visceral pain	Parietal pain	Referred pain
Occurrence	Hollow abdominalorgans such as intestines becomes distended orforcefully -The capsule of solid organs such as liver or spleen is stretched	The parietal peritoneum becomes inflamed as in appendicitis or peritonitis	Distant sites that are innervated at approximately the samelevels as the disrupted abdominal organ
Location	Poorly defined orlocalized and intermittently timed	Tends to localized moreto the source	Highly localized at thedistant site
Character	Dull. aching, burning, cramping or colicky	More sever and steady pain	Travels or refers from the Primary site

Abdominal pain occurs when specific digestive organs or structure are affected by chemical or mechanical factors as inflammation, infection, distention, obstruction or trauma.

History:-

Are you experiencing abdominal pain?

How would you describe the pain?How bad is the pain severity on a scale of 1 to 10 ,with 10 being the worst

How does the pain begin?

Where is the pain located? Does it move or has it changed from theoriginal location

When does the pain occur (timing and relation to particular events such as eating, exercise, bedtime)

What are the precipitating factors (seems to bring on the pain) exacerbating factors (make it worse) or alleviating factors (make it better)

Is the pain associated with any ofthe following symptoms nausea, vomiting ,diarrhea ,constipation, gas fever, weight loss, fatigue or yellowing of the eyes or skin

Do you experiencing indigestion? Describe. Does anything in particular seem to cause or aggravated this condition
Do you experiencing vomiting nausea? Describe.
Is It triggered by any particular activities, events or other factors?
Have you noticed a change in your appetite

Bowel Elimination
Do you have constipation? Describe. Do you have anyaccompanied symptoms?
Have you experienced diarrhea? Describe .DO you have any accompanied symptoms?
Have you experienced any yellowing of your skin or white ofyour eyes ,itchy skin ,dark urine
(yellow brown or tea colored) orclay colored

Past history
Have you ever had any of the following disorders, ulcers, gastroesophageal reflux, inflammatory or obstructive boweldisease, pancreatitis, gallbladder or liver disease

Have you had any urinary tract disease as infection ,kidney disease or nephritis or kidney stones
Have you ever had abdominal surgery or other trauma to theabdomen

Life Style and HealthPractices
Do you drink? How much? How often

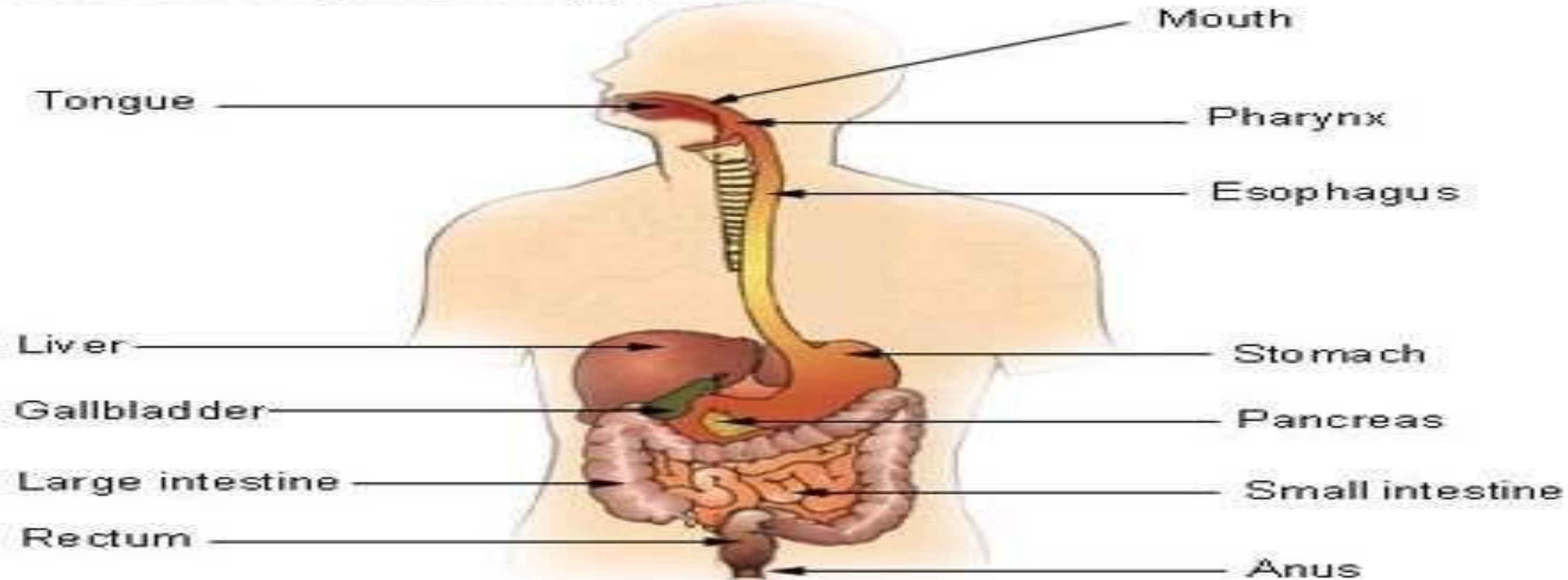
What type of foods and how muchfood do you typically consume each day

How much and how often do you exercise
If you have a gastrointestinal disorder how often does it affect your life style and how you feel about yourself?

Assessing the Abdomen/Gastrointestinal System

When examining the abdomen/gastrointestinal system, ASK about the following:

- Any change in appetite?
- Any difficulty swallowing? (dysphagia)
- Any abdominal pain? (use PQRST pneumonic)
- Any nausea or vomiting? (color, odor, presence of blood, food intake in past 24 hours)
- Any change in bowel habits? (constipation, diarrhea, blood in stool, or dark, tarry stools)
- Do you have any hemorrhoids? (bleeding, treatment)
- Any past history of abdominal problems? (gall bladder, liver, pancreas, digestion, elimination)



Assessing the Abdomen/Gastrointestinal System

Assessment of the abdomen includes inspection, auscultation, percussion and palpation

Inspection:

- For bulges, masses, hernias, ascites, spider nevi, veins, pulsations or movements, or a patient's inability to lie flat.

Palpation:

- Palpate lightly then deeply noting any muscle guarding, rigidity, masses or tenderness (tender areas last)
- Palpate the liver margins (often it is not palpable)
- Palpate the spleen (enlargement occurs withmononucleosis and trauma)
- Palpate the kidneys (enlargement may indicate a mass)
- Assess for rebound tenderness (pain on release of pressure to the abdomen usually indicates peritoneal irritation)
- When acute abdominal pain is present perform the iliopsoas muscle test and obturator test

(* Psoas sign: Pain on passive extension of the right thigh. It is present when the inflamed appendix is retrocecal and overlying the right psoas muscle.

- Obturator sign: Pain on passive internal rotation of the hip when the right knee is flexed.)

- **Abdominal Distension (7 F's):**
  1. Full UB.
  2. Fluid.
  3. Fibroid.
  4. Faces.
  5. Fetus.
  6. Flatus.
  7. Fat.

- **Percussion:**
- Percuss for general tympany, liver span, splenic dullness (dullness over the spleen), costovertebral angle tenderness, presence of fluid wave and shifting dullnesswith ascites

Auscultation:

- Auscultate after inspection so you do not produce falsebowel sound through percussion or palpation;

  auscultate for bowel sounds (normal, hyper- or hypo-active) and bruits. Begin by dividing the abdomen into 4 quadrants, by drawing an imaginary line vertically and horizontally across the abdomen, to intersect at the umbilicus. This will divide the abdomen into:
- Right Upper Quadrant (RUQ)
- Left Upper Quadrant (LUQ)
- Right Lower Quadrant (RLQ)
- Left Lower Quadrant (LLQ
- Auscultation should begin in the right lower quadrant. If bowel sounds are not heard, in order to determine if bowel sounds are truly absent, listen for a total of five minutes

	Special Abdominal Tests	
	1-Ascites	
Test for shifting Dullness For the client has ascites.First in supine position. Then turn clientonto his side	The border between tympany and dullness remain relatively constant throughout position change	The fluid assumes dependent position and produces a dull percussion tone around the flank in supine position and tympany around the umbilical .On sideposition ,tympany is on the top
	2-Appendicitis	
Rebound Tenderness Assess abdominalpain and tenderness Palpate the area of pain and suddenlyrelease pressure	No rebound Tenderness	The client has rebound tenderness whenperceiving sharp stabbing pain as the examiner release pressure from the abdomen (Blumberg's sign).
Rovsing's Sign Palpate deeply in LLQ	No pain	Pain in the RLQ during pressure in theLLQ is a positive Rovsing's sign
Psoas Sign	No abdominal pain	Pain in the RLQ indicates irritation of the iliopsoas muscle due to inflamedappendix
	3d Cholecystitis	due to inflamed
Murphy's sign To assess RUQ pain or tenderness Pressfinger tips under the liver border at the right costal margin While the client inhalingdeeply	No increase in pain	Accentuated sharp pain that causes the client to hold his breath (inspiratory arrest) is associated with acute cholecystitis is a positive Murphy's Sign