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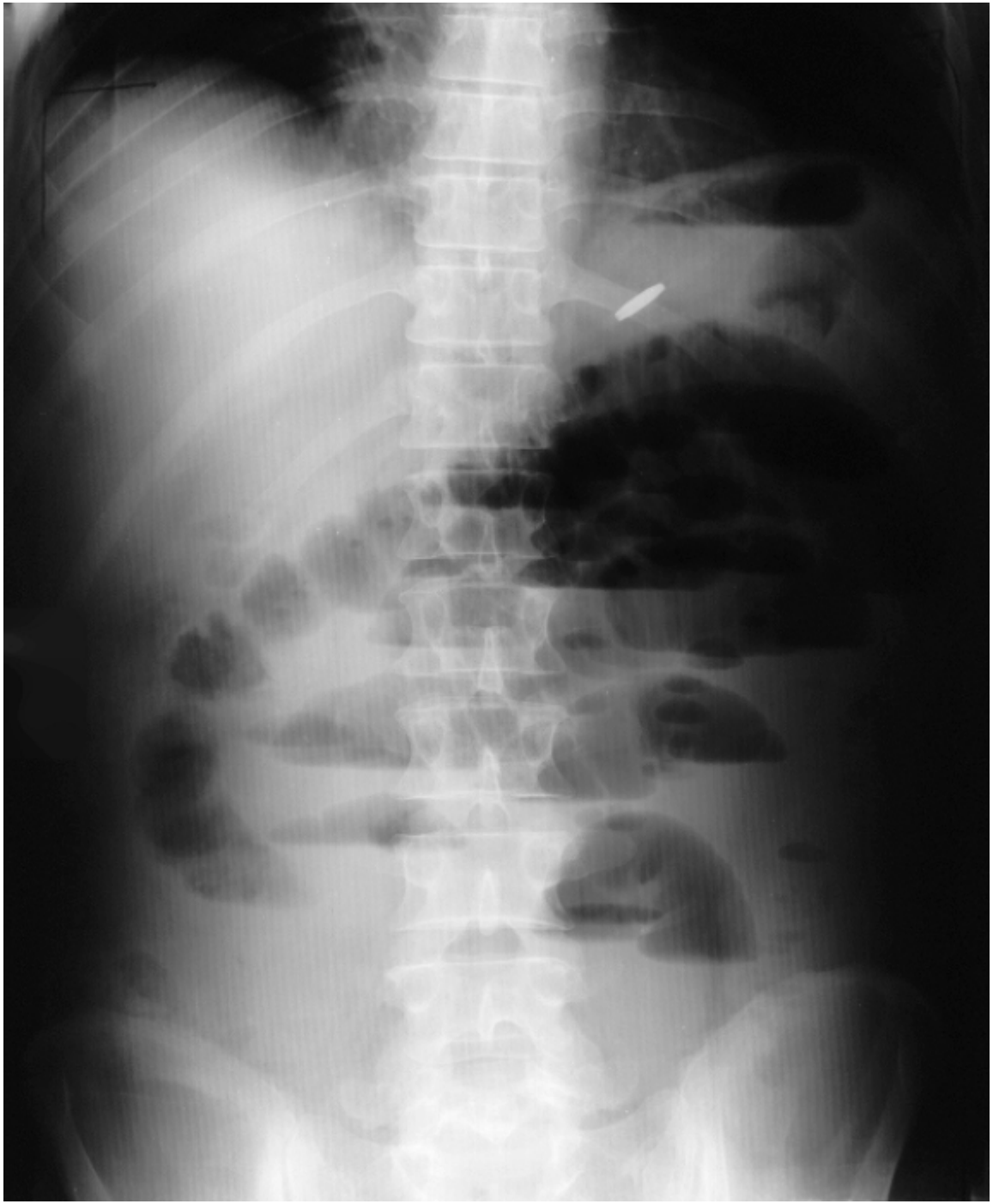
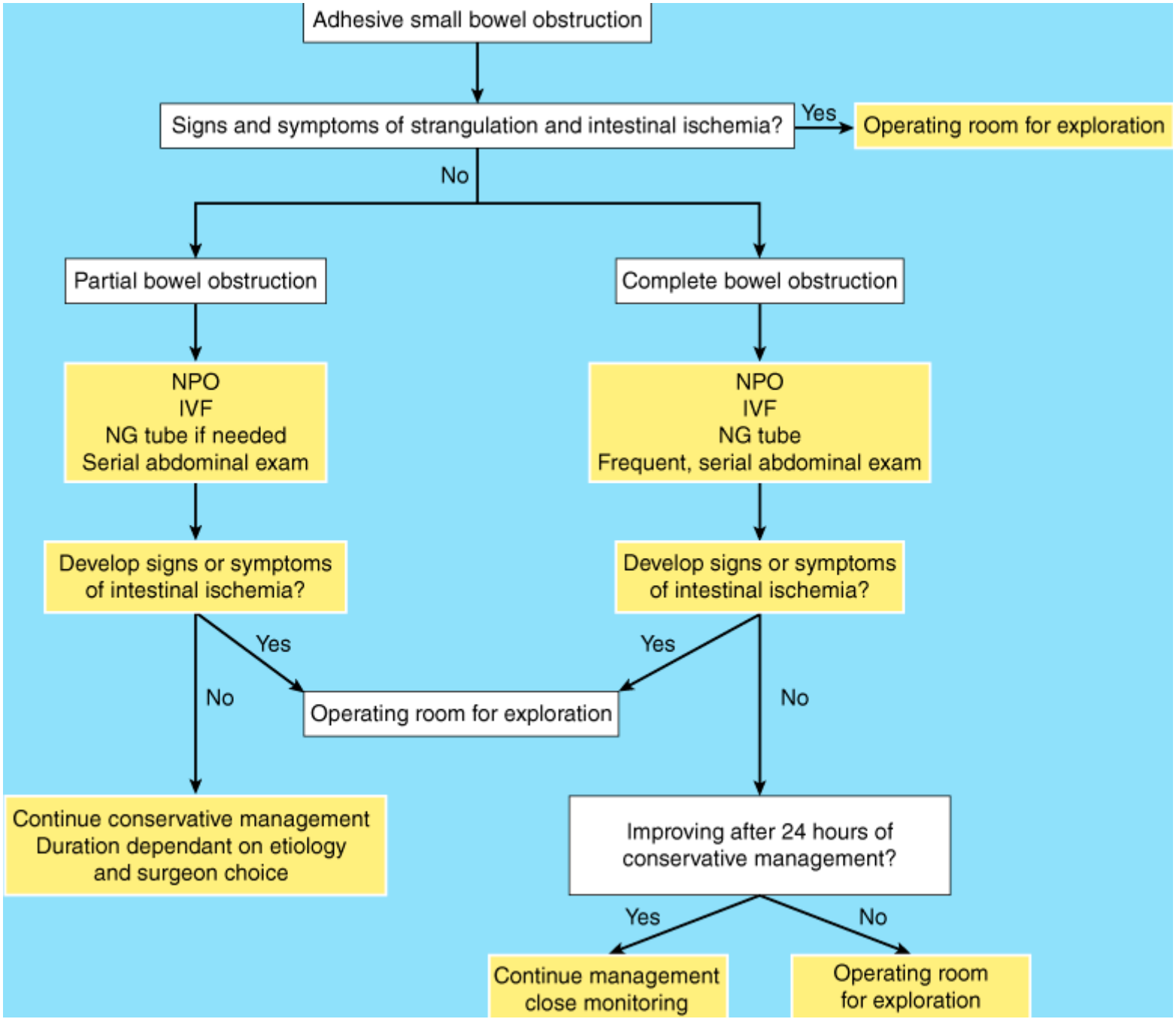
A 70-year-old woman has nausea, vomiting, abdominal distention,and episodic, crampy midabdominal pain. She has no history of previous surgery but has a long history of cholelithiasis for which she has refused surgery. Her abdominal radiograph reveals a spherical density in the right lower quadrant & aerobilia. Correct treatment should consist of Ileotomy and extraction.

Small bowel obstruction. Supine abdominal X-ray (AXR) showing multiple dilated gas-filled loops of small bowel.



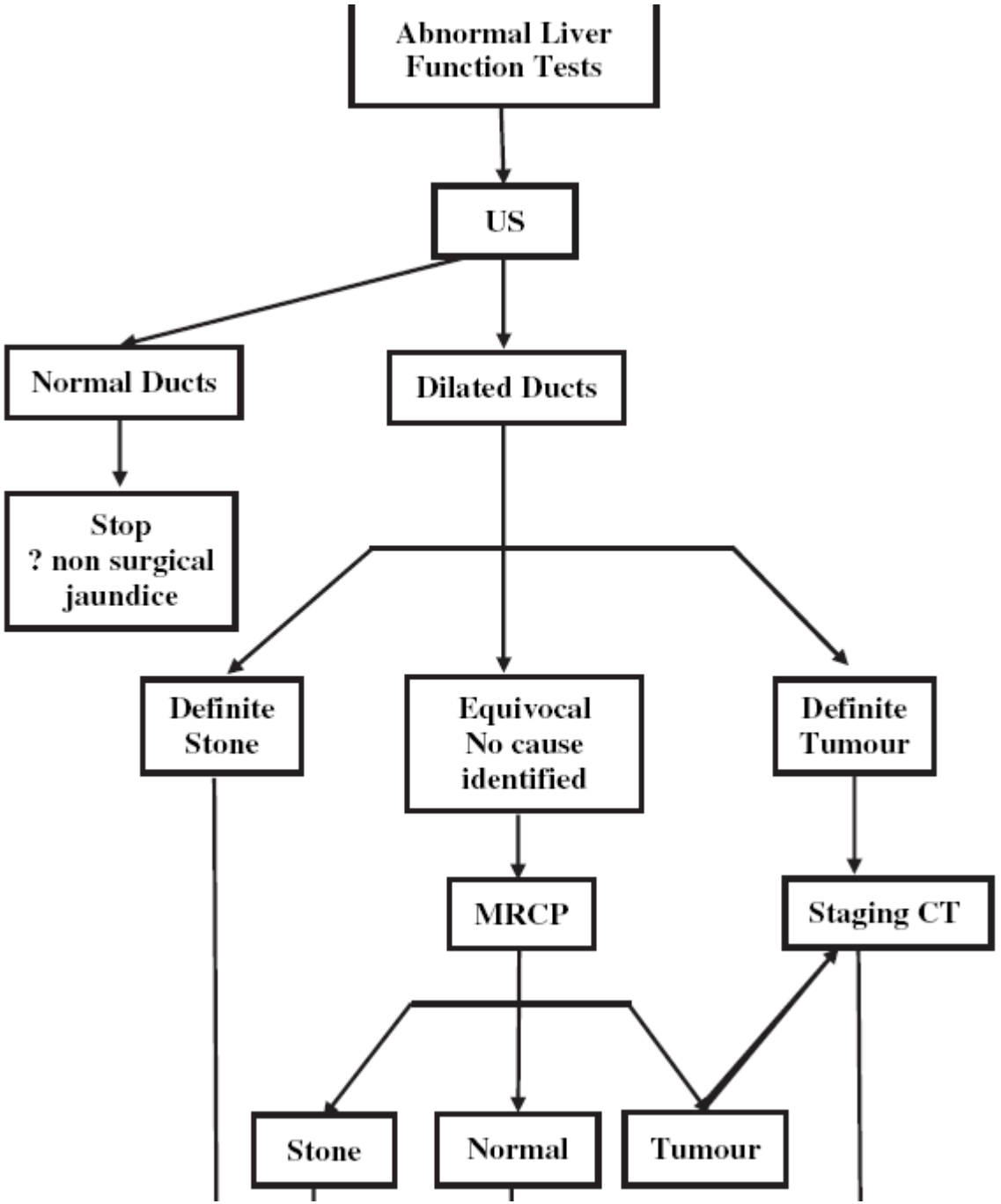
Small bowel obstruction. Erect AXR on the same patient showing multiple fluid levels.

Table 28-3 Small Bowel Obstruction: Common Etiologies
Adhesions
Neoplasms
Primary small bowel neoplasms
Secondary small bowel cancer (e.g., melanoma-derived metastasis)
Local invasion by intra-abdominal malignancy (e.g., desmoid tumors)
Carcinomatosis
Hernias
External (e.g., inguinal and femoral)
Internal (e.g., following Roux-en-Y gastric bypass surgery)
Crohn's disease
Volvulus
Intussusception
Radiation-induced stricture
Postischemic stricture
Foreign body
Gallstone ileus
Diverticulitis
Meckel's diverticulum
Hematoma
Congenital abnormalities (e.g., webs, duplications, and malrotation)

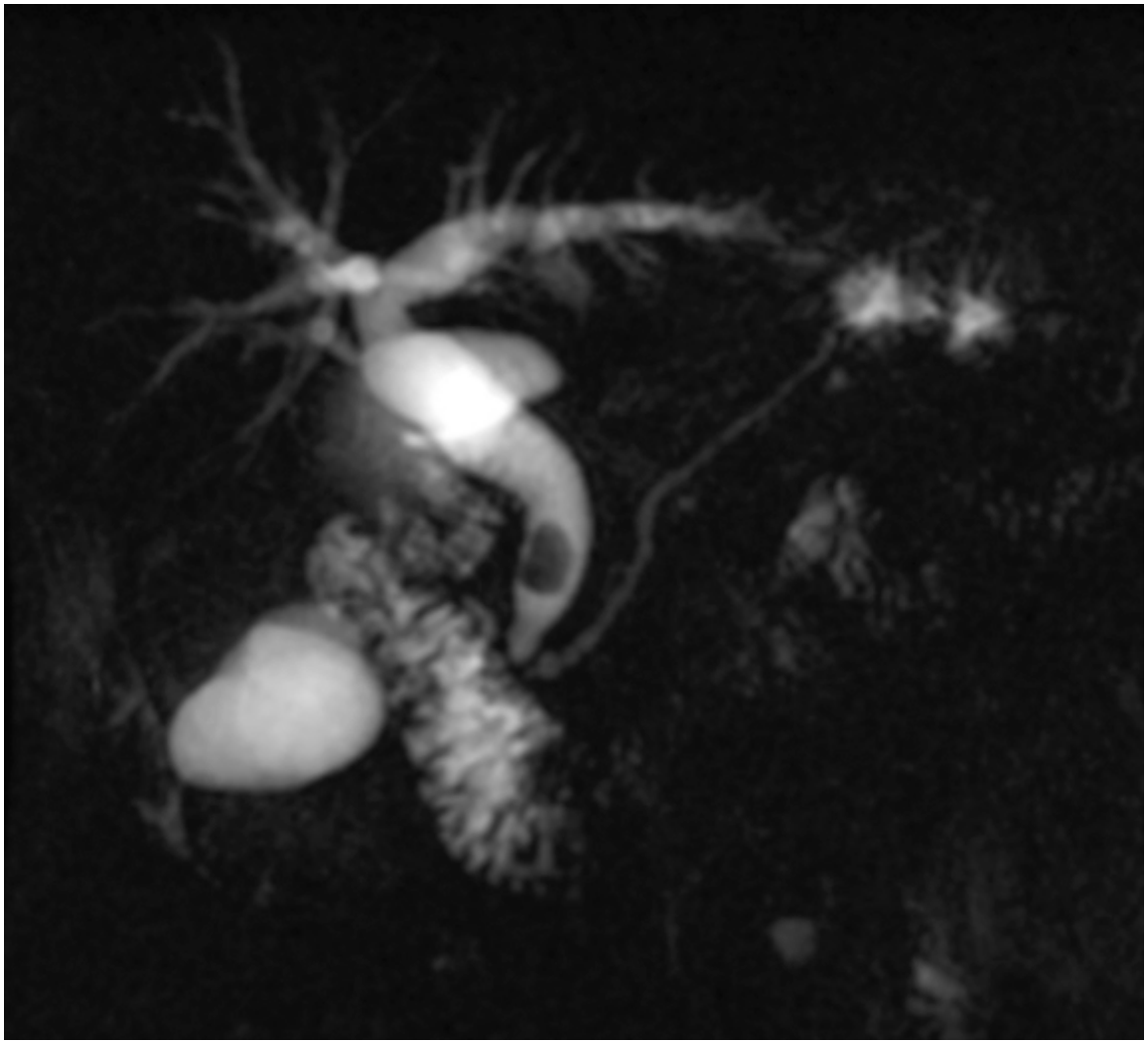


A 58-year-old woman presents to your office complaining of generalized itching.
On examination, she appears jaundiced. During your interview, you learn that she has experienced a I0-Ib weight loss over the past several months and recently has noted the passage of tea-colored urine. Her past medical history is significant for type II diabetes mellitus that was diagnosed 5 months previously,
and she denies any history of hepatitis. She smokes one pack of cigarettes a day but does not consume alcohol. Her temperature and the remainder of her vital signs are within normal limits. The abdomen is soft and nontender. The gallbladder is palpable but without tenderness. Her stool is Hemoccult negative. Laboratory evaluations reveals a normal complete blood count and total bilirubin 12.5 mg/dL, direct bilirubin 10.8 mg/dL, AST 120 u/L, ALT 109 U/L. alkaline phosphatase 348 mg/dL, and serum amylase 85 lU/l.

Carcinoma of the head of the pancreas. Arterial phase CECT of the abdomen showing a low-attenuation lesion (arrow) within the normal enhancing pancreatic head representing a pancreatic carcinoma.



Gallbladder stones. US of the gallbladder
demonstrating two echogenic foci within the gallbladder representing gallbladder stones.



Common bile duct stones. MRCP image demonstrating a well-defined low-signal-intensity filling defect within the common bile duct representing a stone.

A 63-year-old man is rescued from a house fire and brought to the emergency Department.The victim was found unconscious in ,the upstairs bedroom of a house. The patient‘s past medical problems are unknown. His pulse is II2/min. blood pressure 150/85. and respiratory rate 30/min. A pulse oximeter registers 92% O2 saturation with a face mask. He face and the exposed portions of his body are covered with a carbonaceous deposit.He has blistering and open burn wounds involving the circumference of his left am and left leg ,more than 80% of his back and buttocks. He docs not respond verbally to questions and reacts to painful stimulation with occasional moans.

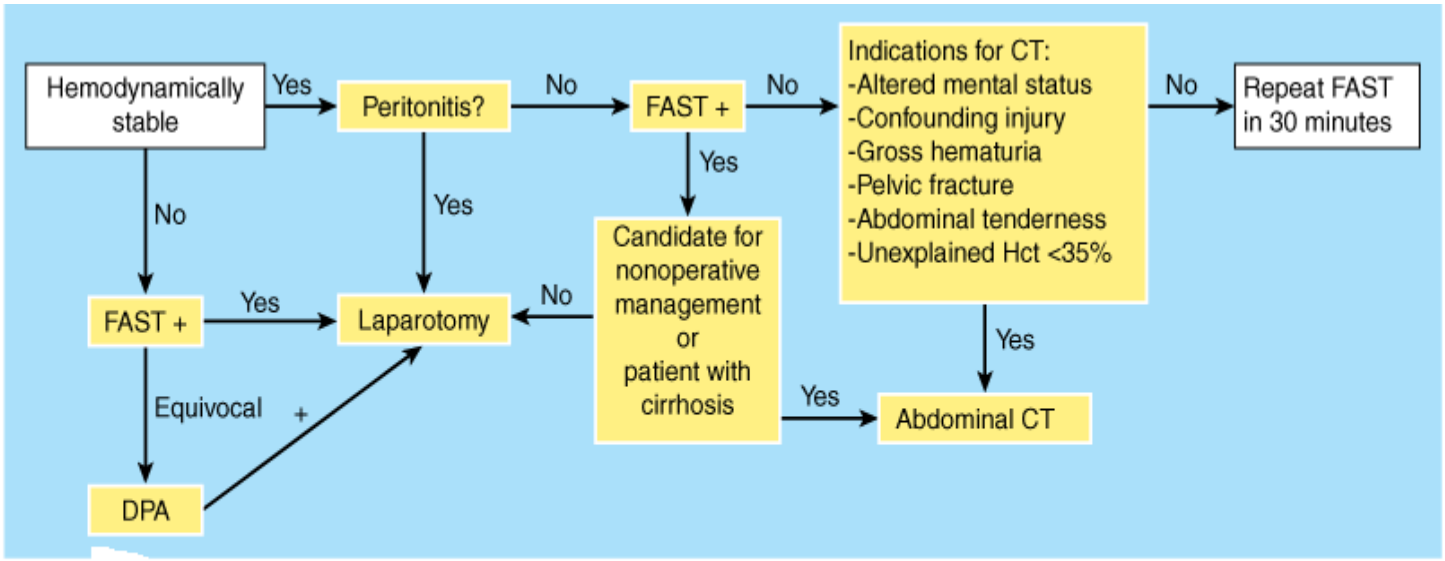
Fluid needs are estimated by the Parkland or Baxter formula. Based on the Parkland formula, for adults and children weighing more than 10 kg, the total 24-hour volume is calculated using 3 to 4 ml/kg/% burn. Half of this amount is given in the first 8 hours, and the remainder in the next 16 hours. Intravenous fluid hydration given by the paramedics en route should be considered part of this volume. Children weighing less than 10 kg should be given 2 to 3 ml/kg/% bum divided similarly over the next 24 hours. In addition, they should receive a maintenance fluid that includes 5% dextrose. Because of the increased capillary permeability, colloids such as albumin are generally avoided for the first(12 to 18 hours but can be used subsequently if resuscitation is not being achieved with the crystalloid regimen. Inhalational injuries, extensive deep burns, and delayed resuscitation usually result in larger fluid requirements than initially calculated.

Assessing the Adequacy of Resuscitation

Measuring urine output (UOP) is a helpful way of assessing the adequacy of the resuscitation. Adults should achieve 0.5 ml/kg/hour of UQP, children should produce 0.5 to I ml/kg/h, and infants should produce I to 2 ml/kg/h Because they have a higher volume-to-surface area ratio. Generally. UQP is averaged over 2 to 3 hours before changes are made. Excess UOP should also be avoided unless one is treating myoglobinuria.

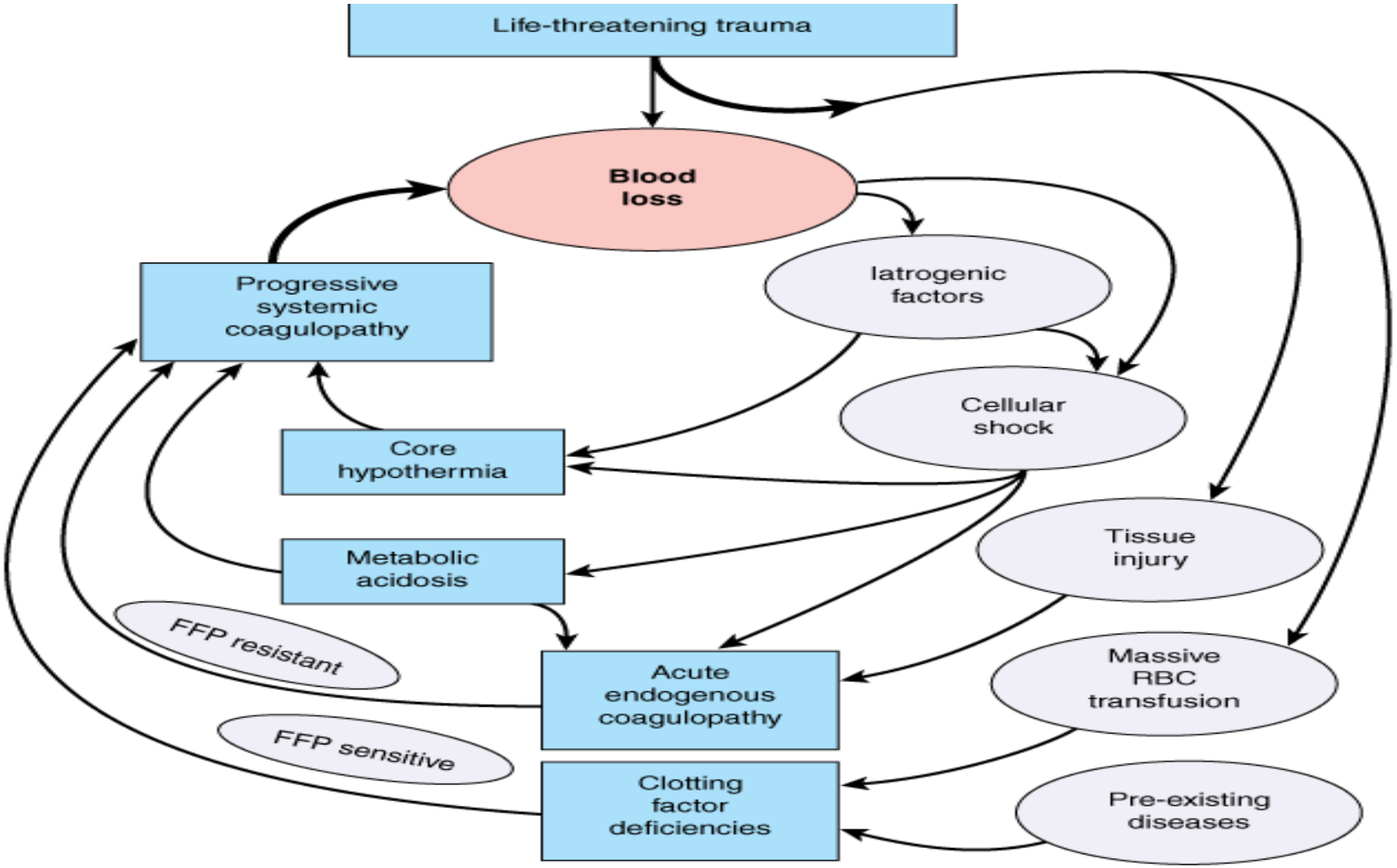
	Fluid preparation			
($mmol\,l^{-1}$)	0.9% saline	5% dextrose	Dextrose (4%) saline (0.18%)	Hartmann's solution
Na^+	155	0	30	131
K^+	0	0	0	5
Ca^+	0	0	0	2
Cl^-	155	0	30	111
HCO_3^-	0	0	0	29
Glucose	0	278	222	0
Distribution in body water	ECF	ECF	$^1/_2$ ECF; $^1/_2$ ICF	ECF

A 30-year-old woman for an acute visit 16 days postpartum. She has been nursing her baby daughter but has developed a very sore left breast. On examination, the patient is afebrile. The breast is diffusely tender but primarily in the upper inner quadrant. The skin overlying the area of most tenderness is erythematous and warm. The remainder of the examination is normal.



Algorithm for the initial evaluation of a patient with suspected blunt abdominal trauma. CT = computed tomography; DPA = diagnostic peritoneal aspiration; FAST = focused abdominal sonography for trauma; Hct = hematocrit.

The bloody vicious cycle



THANK YOU