MBChB Year 2 Clinical contact in GP – Abdominal symptoms 12th February 2026

Overview of the abdominal symptoms session in GP clinical contact

The Intended Learning Outcomes for this session are:

Undertake a clinical consultation & gather information relevant to the patient presentation
Describe & perform a clinical examination relevant to the patient presentation including vital signs
Practise formulating a differential diagnosis
Practise presenting the patient and be able to discuss the differential diagnosis and management options

The aims for this session are:

- To discuss the assessment of abdominal pain and associated abdominal symptoms in Primary care.
- Practise consulting and examination (preferably abdominal).
- Link university learning to Primary Care and share your clinical experience.

Common to all sessions:

- refer to the Year 2 GP handbook, which covers the information common to all sessions.
- Please see Session plans for Clinical contact in GP year 2 (2025-26) also attached to this email to help you structure time with your group.

Allow time for:

- Identifying one or two learning points/things to look-up for next time.
- If possible, allow some time to reflect on the sessions so far. How are the students finding the sessions? Anything they would like to do differently?

(Expert) patients

Suitable patients for the block are someone who has:

- Patients with chronic or recurrent conditions causing abdominal pain, jaundice or change in bowel habit.
- Patients with a previous episode of acute abdominal pain e.g. previous gallstones/pancreatitis/appendicitis etc.
- Any patient suitable for an abdominal examination

Context for the session

Students will have covered the following in the two-week abdominal symptoms block:

In **Case-Based Learning** they consider a 75-year-old woman with a history of ischaemic heart disease and sudden onset abdominal pain, due to infarction of her small bowel.

In **Lectures, workshops and practical** they learn about:

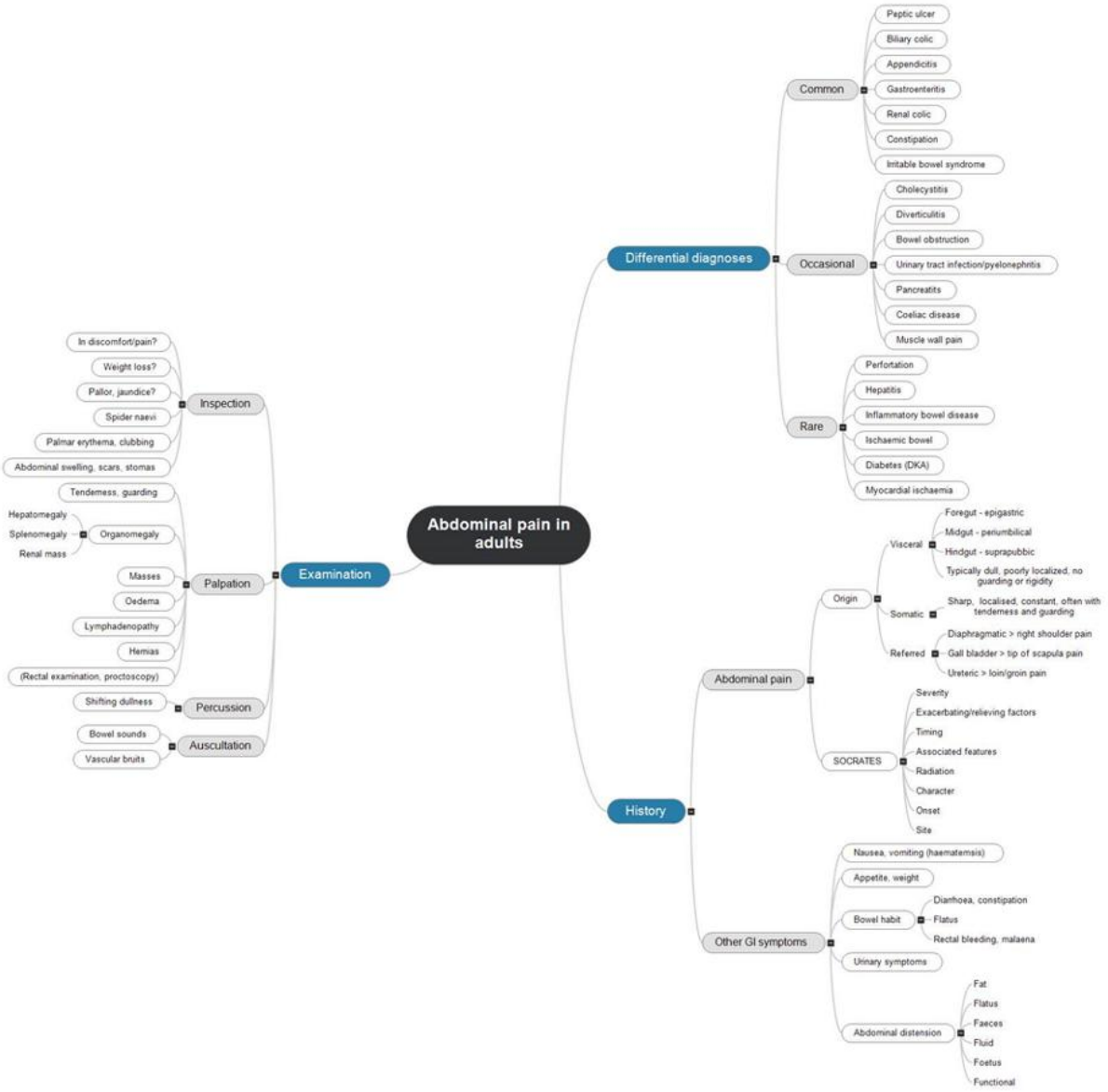
- Biochemical aspects of nutrition and metabolism
- Causes and investigations of upper and lower GI bleeding
- The normal function of the liver and the clinical features of acute and chronic liver disease
- Abdominal pain (referred, colicky and peritonitic), including in special circumstances.
- Symptoms and investigations of viral and bacterial infections of the GI tract, including hepatitis
- Symptoms, signs and investigations of altered bowel habit and GI tract malignancy

In their **Effective consulting labs** they will:

- Meet and consult with a simulated patient with upper abdominal pain and consider the abdominal pain history and differential diagnosis
- They will also consider assessing patients' alcohol use and motivational interview skills

Brainstorm for abdominal symptoms in GP clinical contact – see mind map on next page

- What do students know about abdominal pain and its causes? See mind map on following page
- How do patients with pathology of the GI tract present?
- Are there any links between their previous cases e.g. anaemia, bleeding and clotting, chest pain or breathlessness that link to pathology of the gastrointestinal tract?
- How do you assess a patient with abdominal pain?
- What are serious features that you look out for in a patient presenting with abdominal pain?


Abdominal pain in adults
Differential diagnoses
Common
Peptic ulcer
Biliary colic
Appendicitis
Gastroenteritis
Renal colic
Constipation
Irritable bowel syndrome
Occasional
Cholecystitis
Diverticulitis
Bowel obstruction
Urinary tract infection/pyelonephritis
Pancreatitis
Coeliac disease
Muscle wall pain
Rare
Perforation
Hepatitis
Inflammatory bowel disease
Ischaemic bowel
Diabetes (DKA)
Myocardial ischaemia
History
Abdominal pain
Origin
Visceral
Foregut - epigastric
Midgut - periumbilical
Hindgut - suprapubbic
Typically dull, poorly localized, no guarding or rigidity
Somatic
Sharp, localised, constant, often with tenderness and guarding
Referred
Diaphragmatic > right shoulder pain
Gall bladder > tip of scapula pain
Ureteric > loin/groin pain
SOCRATES
Severity
Exacerbating/relieving factors
Timing
Associated features
Radiation
Character
Onset
Site
Other GI symptoms
Nausea, vomiting (haematemsis)
Appetite, weight
Bowel habit
Diarrhoea, constipation
Flatus
Rectal bleeding, malaena
Urinary symptoms
Abdominal distension
Fat
Flatus
Faeces
Fluid
Foetus
Functional
Examination
Inspection
In discomfort/pain?
Weight loss?
Pallor, jaundice?
Spider naevi
Palmar erythema, clubbing
Abdominal swelling, scars, stomas
Palpation
Tenderness, guarding
Organomegaly
Hepatomegaly
Splenomegaly
Renal mass
Masses
Oedema
Lymphadenopathy
Hernias
(Rectal examination, proctoscopy)
Percussion
Shifting dullness
Auscultation
Bowel sounds
Vascular bruits

Student information

Gastrointestinal symptoms are common. Symptoms suggesting a serious diagnosis include:

- dysphagia (difficulty swallowing)
- gastrointestinal bleeding
- persistent vomiting or diarrhoea
- fever
- anaemia
- weight loss
- nocturnal symptoms e.g. abdominal pain that wakes a patient from sleep or waking to open bowels

The risk of serious disease increases with age.

Causes of abdominal pain:

Gastro-oesophageal reflux disease (GORD)/dyspepsia: the pain is typically a hot, burning retrosternal (GORD) or epigastric discomfort (dyspepsia). May be associated with an acid or bitter taste in the mouth, sudden filling of the mouth with saliva ("waterbrash"), nausea, bloating and belching. May be precipitated by lying down or bending forwards and by meals especially fatty or spicy foods; and relieved by antacids and proton-pump inhibitors.

Peptic ulcer: includes both gastric and duodenal ulcers. Characterised by epigastric pain and tenderness usually occurring 1-3 hours after eating. It may be associated with an iron-deficiency anaemia due to a bleeding ulcer, or a bleeding ulcer may present acutely with haematemesis or melaena (red flags).

Biliary colic is caused by gallstones getting stuck in the bile ducts. It is characterised by sudden onset, constant epigastric or right hypochondrium pain which may radiate to the right scapula. The pain may be precipitated by eating and may last for up to 24 hours before resolving spontaneously.

Cholecystitis is inflammation of the gallbladder. The patient may have a history of gallstones or biliary colic. The pain may be similar to biliary colic but fever, vomiting and severe tenderness in the right hypochondrium make a diagnosis of cholecystitis more likely. **Ascending cholangitis** is infection of the biliary tree and patients can become septic quickly; think of this if the patient presents with fever, right upper quadrant pain and jaundice.

Pancreatitis: severe epigastric pain radiating to the back and associated with vomiting. The patient may be very unwell with epigastric or generalised tenderness, tachycardia and hypotension. Alcohol is a common and important cause of pancreatitis.

Appendicitis: generalised periumbilical pain progresses to localised pain and tenderness in the right iliac fossa. Moving and coughing aggravate the pain. Associated with nausea, anorexia and low-grade fever.

Diverticulitis: means inflammation of small outpouchings (diverticulae) from the wall of the colon. Most commonly presents with left lower quadrant pain and localised tenderness (more commonly right lower quadrant in Asian patients). Associated with fever, tachycardia and change in bowel habit (commonly diarrhoea +/- blood).

Inflammatory bowel disease: includes Crohn's disease and ulcerative colitis. Usually presents with diarrhoea containing blood. The patient may also experience generalised or cramping abdominal pain, weight loss, fever and symptoms of anaemia.

Irritable bowel syndrome: a functional disorder which causes chronic abdominal pain, bloating or change in bowel habit (diarrhoea or constipation). Abdominal pain may be relieved by defecation. Symptoms may be precipitated by stress.

Coeliac disease: an autoimmune condition which is provoked by eating gluten. It presents with a range of symptoms including generalised abdominal pain, bloating, change in bowel habit (diarrhoea or constipation), weight loss, mouth ulcers and anaemia. The patient may notice that their symptoms are precipitated by eating foods containing gluten.

Bowel ischaemia/infarction: occurs when the blood supply to an area of the gut is blocked. The patient will complain of moderate to severe abdominal pain but there may be little or no tenderness at the start – this is unusual given the degree of pain which the patient feels.

Tumours including bowel cancer: tumours can affect any abdominal organ and present with pain. Bowel tumours may present with a change in bowel habit or bleeding from the GI tract.

Perforated viscus and peritonitis: a hole can form in any hollow organ in the abdomen and can be caused by a variety of conditions. Peritonitis is inflammation of the peritoneum and can be caused by a perforated viscus. The patient will experience sudden onset, severe pain and is likely to be very unwell. The patient will usually lie very still.

Abdominal aortic aneurysm (AAA) dissection: a tear in the wall of the aorta. It usually causes a tearing, shearing pain which radiates to the back. Mortality is very high, and patients usually present as an emergency.

Bowel obstruction: obstruction of the bowel may be caused by many conditions including tumours, narrowing or twisting of the bowel, foreign bodies and hernias. The patient will present with absolute constipation (no flatus), vomiting, abdominal distension and generalised abdominal pain.

Summary of the abdominal pain history (includes tips on asking sensitive questions)

<table>
<tr><td> 
</td><td>Introduction
Abdominal pain has a broad differential diagnosis, ranging from mild, self-limiting conditions (e.g. constipation, gastroenteritis) to serious and potentially life-threatening causes (e.g. abdominal aortic aneurysm, ruptured ectopic pregnancy). When taking a history from a patient with abdominal pain, it is essential to identify features that may indicate a serious underlying pathology requiring urgent investigation and treatment.</td></tr>
<tr><td colspan="2">You can use SOCRATES to assess abdominal pain</td></tr>
<tr><td colspan="2">SITE: Patients may find it difficult to localise the pain. The site of pain relates to the embryological origins of abdominal organs:
○ Epigastric pain relates to foregut structures (stomach, duodenum, liver, pancreas, gallbladder).</td></tr>
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- Periumbilical pain relates to **midgut** structures (small and large intestines including appendix).
- Suprapubic pain relates to **hindgut** structures (rectum and urogenital organs) e.g. urinary tract infection, urinary retention, testicular torsion, pelvic inflammatory disease (PID)
    - Right iliac fossa pain includes appendicitis, ectopic pregnancy, mesenteric adenitis, torsion of ovarian cyst, PID
    - Left iliac fossa pain includes diverticulitis, ectopic pregnancy, torsion of ovarian cyst, PID
- Flank pain may be renal colic or pyelonephritis
- A very localised pain may originate from the parietal peritoneum e.g. appendicitis when the inflammation spreads to the peritoneum overlying the appendix (pain moves from the midgut region)

ONSET: With sudden onset of severe abdominal pain, you need to consider life threatening causes, pain that develops over hours is more likely with infection or inflammation.

- **Acute abdominal pain** is usually sudden in onset and most commonly reflects inflammation, obstruction, ischaemia, perforation or torsion, spanning gastrointestinal (e.g. appendicitis, diverticulitis, obstruction), hepatobiliary/pancreatic (e.g. biliary colic, cholecystitis, acute pancreatitis), genitourinary, gynaecological and vascular emergencies such as ruptured AAA. These causes often have systemic features (fever, vomiting, haemodynamic compromise) and may require urgent intervention.
- **Chronic abdominal pain** is typically persistent or recurrent and is more often due to malignancy, chronic inflammatory or autoimmune disease, functional disorders, or structural enlargement (e.g. splenomegaly, fibroids). Gastrointestinal causes (IBD, coeliac disease, IBS, chronic constipation) predominate, alongside hepatobiliary/pancreatic malignancy, chronic pelvic or gynaecological disease, and metabolic causes such as hypercalcaemia.

CHARACTER: "How would you describe the pain? Does it come and go or is it constant?" Pain that comes and goes indicates obstruction of a hollow muscular-walled organ e.g. intestine, gallbladder, bile duct, ureter). Burning pain indicates an acid cause.

RADIATION: "Does the pain spread anywhere else?" Gallbladder pain may radiate to the right scapula. Shoulder-tip pain occurs with diaphragmatic irritation. Radiation to the back may indicate pancreatitis or aortic dissection. Renal colic pain may radiate from the loin to the groin.

ASSOCIATED SYMPTOMS: Anorexia, nausea and vomiting are common but may be non-specific. Altered bowel habit may occur with irritable bowel syndrome, diverticular disease and colorectal cancer. Sweating, hypotension and tachycardia may suggest a perforated viscus or AAA dissection.

TIMING: Appendicitis may present with generalised central abdominal pain which then 'moves to' the right iliac fossa. Pain after eating suggests dyspepsia or biliary origin.

EXACERBATING/RELIEVING FACTORS: "Does anything make the pain better? Does anything make the pain worse or bring the pain on?" "What were you doing when the pain started?"

Pain exacerbated by movement or coughing suggests inflammation, patients may lie very still. Patients with colicky pain tend to move around or draw their knees up to their chest. Sitting forward may help with pain of a pancreatic origin. In irritable bowel syndrome, pain may be relieved by passing flatus or defaecating.

SEVERITY: Ask about pain scale of 0-10 "On a scale of **0 to 10**, where 0 is no pain and 10 is the worst pain you can imagine, **how would you rate your pain right now**?"

For chronic or acute on chronic pain you can ask about average pain: "Over the last week, what number best describes your average pain?" **Worst pain**: "What number does it reach at its worst?" **Best pain**: "What's the lowest it gets?"

What is normal and what has changed?

Ask about changes to weight and bowel habit and, if appropriate, normal menstrual pattern and any changes and any chance of pregnancy

Bowel habit:

- What is the patient's normal bowel habit and how has it changed? Ask about frequency, consistency and colour of stool. Ask about presence of blood (red blood or black, tarry stool – melaena) and mucus. Discussing stool consistency with patients can be helped by using the Bristol stool chart.
- A patient's bowel habit can change for a variety of reasons, some of which are serious. It is important to identify any associated "red flags" (blood in the stool; unintentional or unexplained weight loss; abdominal or rectal mass; anaemia; family history of bowel or ovarian cancer).

Causes of a change in bowel habit include:

- Bowel cancer
- Infective diarrhoea
- Irritable bowel syndrome
- Inflammatory bowel disease
- Coeliac disease
- Bowel obstruction

If appropriate ask about sexual and genital contact: Pelvic inflammatory disease can cause lower abdominal pain. It is important to consider **ectopic pregnancy** in all female patients of childbearing age

Associated symptoms

- dysphagia (difficulty swallowing): establish timeline and whether it occurs with liquid or solids, if there is associated pain with swallowing and if there is any regurgitation of food
- nausea and vomiting: vomit containing blood (fresh red or coffee-ground) suggests an upper GI bleed. Vomit containing bile (green) suggests an upper GI obstruction. Faeculant vomiting suggests a lower GI obstruction.
- jaundice: yellowish discolouration of the skin, sclerae and mucus membranes. Ask about the colour of the urine and stool. Ask if patient has any itching (pruritus).
- urinary symptoms: frequency, dysuria, incontinence.

- appetite and weight loss/ change in weight including timescale
- fever

SYSTEMS REVIEW – A brief overview (not exhaustive). What you ask depends on the presenting problem and situation and what you have already covered

Systemic: Fever, weight loss, pain.
Cardiovascular & Respiratory: Chest pain, breathlessness (including PND & orthopnoea) palpitations, ankle swelling, cough, wheeze, exercise tolerance normally and any recent change.
Gastrointestinal: Appetite, weight, abdominal pain, swallowing, nausea, changes in bowel habit, jaundice, stool appearance/blood.
Genitourinary: Urinary symptoms (hesitancy, terminal dribbling, dysuria, haematuria, nocturia, incontinence, discharge), menstrual history, pregnancy.
Neurological: Memory, vision, hearing, headaches, fits, faints, funny turns, mood changes, unsteadiness, weakness.
Musculoskeletal: Injuries, joint pain/swelling, muscle pain.
Dermatological: Rash, skin lesions, ulcers

Area e.g. past medical and surgical history

- Previous surgery
- Chronic bowel diseases e.g. Crohn's, ulcerative colitis
- **Associated** conditions: cardiovascular risk factors may suggest AAA or ischaemic bowel. Autoimmune conditions, such as type 1 diabetes and thyroid disease, may be associated with non-alcoholic fatty liver disease and autoimmune hepatitis

Medication history – please see specific medication history

Many drugs affect the GI system and cause gastrointestinal side effects. Medication may also be nephrotoxic or hepatotoxic.
It is important to assess contraceptive use in patients with a uterus of childbearing age

Family history

Risk of certain conditions increase if a first-degree relative has the condition e.g. colorectal cancer, polyps, Crohn's, ulcerative colitis.

Social, lifestyle and wellbeing – please see specific social and lifestyle history & the "Lifie"

- What is their diet like? Excessive alcohol consumption is a modifiable risk factor for liver disease.
- Smoking is a modifiable risk factor for peptic ulceration, oesophageal cancer and colorectal cancer.
- Intravenous drug use, tattoos, foreign travel, blood transfusions, sexual history are risk factors for viral hepatitis.

PATIENT PERSPECTIVE (IDEAS, CONCERNS, EXPECTATIONS, IMPACT & EMOTIONS)

Ideas. What do they think is going on? Possible causes? What have they tried already? Sources of info e.g. What does your partner/ family think?
Concerns. What are they worried is going on or will happen?
Expectations. What are they hoping for?
Impact. How is the problem affecting them?
Emotions. What are the predominant emotions around the problem? Psychological impact.

Top tips on asking sensitive questions

To be able to understand the possible cause of abdominal pain or other symptoms, you will need to ask patients personal questions about their bowel habit, weight, menstrual cycle sexual activity, and chance of pregnancy. Some patients may feel embarrassed about this too.
The following approach can help:

- **Explain why you're asking**
- **Ask permission**
- **Use neutral, inclusive language**
- **Avoid assumptions** (about gender, partners, fertility, or activity)

Prepare the patient and set the context. Explain why you are asking and make sure the questions are clinically relevant. You may need to address confidentiality and check who is with the patient and who you will share information with e.g. the clinical team:

- "I need to ask you about your lifestyle to better understand your situation"
- "I'm going to ask you about your bowel habit to better understand how your gut is working"

Ask permission

- "Would it be okay if I ask you about your alcohol intake?"
- "If you don't mind, I would like to ask you some questions about your lifestyle?"

Normalise the questions e.g., frame them as part of your usual medical enquiry (but be careful with leading questions)

- "I always ask about alcohol intake because it has an important impact on overall health …"
- "Bowel habit can vary widely from one person to the next. How often do you open your bowels?"
- "I ask this routinely of anyone who has a uterus because it can affect causes of abdominal pain. Is there any chance you could be pregnant?" or "Some causes of abdominal pain relate to pregnancy— is there any chance you could be pregnant at the moment?"
- "Sometimes abdominal pain can be caused by an infection, so I need to ask a couple of questions about sexual or genital contact" and seek permission: "Would it be okay to talk about that now?"

Talk in matter of fact, factual terms and avoid assumptions.

- "Talk me through what you eat in a typical day?"
- "Do you ever have a drink containing alcohol?
- "How many drinks containing alcohol do you typically have on a single occasion?"
- "How often do you have a drink containing alcohol in an average week?"
- "Have you had any sexual or genital contact recently?"
- "How often do you open your bowels?"
- "Has your weight changed recently?"

Closed questions and a "menu" of responses. When asking sensitive questions, closed questions can help relieve anxiety about how to answer, as can giving a menu of responses.

- "Do you open your bowels: every day, several times a day, or do you go for a day or more without opening your bowels?"

PITFALLS:

Avoid excessive apologising and make sure that what you are asking is clinically relevant

Avoid making assumptions. Avoid assumptions such as "Do you eat a healthy diet?" or "Do you have a boyfriend?". You will cover more on the sexual history later in your training. When it is appropriate to ask about sexual behaviour the same principles apply as for any sensitive questions:

explain why you are asking and ask permission; not everyone is sexually active, not everyone has the same anatomy, and not everyone identifies the same way.

Language – use clear, jargon free communication and simple or plain language

Not all patients understand references to language such as “bowel habit” or “stool” and most people are comfortable with being asked when they last had a poo/how often they poo; the same applies to “pee” or “wee” (instead of urine). To read more about health literacy see here: Health Information - Knowledge and Library Services