Abdominal, GI Bleeding, GU and Dialysis Emergencies

Paramedic picture, ALS step and destination for GI bleeding, the acute abdomen, swallowed objects and tubes, children, genitourinary and gynecologic emergencies and the dialysis patient

Medic Basics
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EVERY ABDOMEN: FIRST STEPS

- Hunt the life threats (NASEMSO): ischemic or perforated bowel, AAA or dissection (aortic-htn), ruptured ectopic, appendicitis, cholecystitis, pyelonephritis. High risk: older, anticoagulated, under 2, immunocompromised.
- Shock (NASEMSO): 500 mL isotonic boluses toward MAP 65, up to 30 mL/kg; stop for pulmonary edema; blood if carried; IO after two failed IV attempts.
- Treat pain: analgesia does not hide the diagnosis (Merck). Fentanyl and ondansetron doses: ems-pharmacology. Ketorolac 15 mg IV or 30 mg IM, not with hypotension, kidney disease, peptic ulcer or pregnancy (NASEMSO).
- Nothing by mouth; vomiting blood or altered: on the side, suction ready.
- Consider pregnancy in any female 10 to 60 years (NASEMSO); early pregnancy: emt-by-complaint, ob-emergencies.

GI BLEEDING

PICTURE	CLUES	PARAMEDIC ACTION
Upper GI bleed	Coffee-ground emesis, melena; NSAIDs, anticoagulants	Two large-bore IVs, fluid to perfusion, endoscopy-capable hospital
Melena with syncope	Faint, pallor, sweats; supine BP may look normal	Significant loss: keep supine, no orthostatic checks, IV, transport
Bright red per rectum on an anticoagulant	Usually lower GI; a brisk upper bleed can also do it	Measured boluses; report the drug and last dose for reversal
Varices (cirrhosis)	Sudden painless large hematemesis, ascites, confusion	Airway first, side and suction, measured boluses toward MAP 65, rapid transport
Cirrhosis turning confused	Asterixis plus melena or a BP below baseline	GI bleeding triggers encephalopathy: treat the bleed; beta blockers blunt HR

SAFETY No TXA for GI bleeding. HALT-IT (12,009 patients): bleeding deaths 3.7% vs 3.8%, venous clots 0.8% vs 0.4%. Field TXA is for trauma within 3 h (and PPH).

ACUTE ABDOMEN IN ADULTS

CONDITION	CLUES	PARAMEDIC POINT
Pancreatitis	Steady boring epigastric pain to the back; alcohol, gallstones; flank or navel bruising is grave	Ringer's lactate 10 mL/kg if dry, then slow; not 20 mL/kg loading
Cholecystitis	RUQ pain over 6 h, to right scapula, Murphy sign, fever	Analgesia, antiemetic, 12-lead for upper abdominal pain
Cholangitis	Pain, jaundice, fever; plus confusion and low BP (Reynolds)	Sepsis alert to a hospital that can drain the duct (ERCP)
Bowel obstruction	Prior surgery or hernia; crampy pain, vomiting, no stool or gas, distension	Nothing by mouth, IV fluid, antiemetic; strangulation can infarct in 6 h
Diverticulitis	LLQ pain, fever, change in bowel habit	Peritoneal signs or sepsis: perforation
Mesenteric ischemia	Atrial fibrillation; severe pain, soft abdomen	Pain out of proportion: prealert, surgical center
Splenic rupture	Mononucleosis, minor or no blow; LUQ and left shoulder pain	Supine, IV, perfusion target, trauma center
Appendicitis in pregnancy	Navel pain that moves, anorexia, fever; may sit in the flank or RUQ	Left side; hospital with obstetrics and surgery
Boerhaave	Forceful vomiting, then chest pain and skin crepitus	Nothing by mouth, shock care; say 'vomiting then chest pain'
Peritonitis, low pain score	Schizophrenia (higher pain thresholds, Stubbs 2015), older, steroids: lies still, rigid, fever, fast HR	Rigidity and vitals outrank the score: sepsis care, surgical center

SWALLOWED OBJECTS, STOMAS AND TUBES

PROBLEM	DECIDING POINT	ACTION
Food bolus	Cannot swallow saliva: complete obstruction	Upright, suction, nothing by mouth; endoscopy now, not tomorrow; no fizzy drinks
Several magnets	Attract across bowel loops: necrosis, perforation	Nothing by mouth, transport for x-ray; one magnet is usually benign
New stoma dark or black	Dry, cool, purple-black days after surgery	Necrosis: cover, do not handle or irrigate, surgical team
G-tube out	Delay risks the tract narrowing; under 4 weeks old is an unhealed tract	Cover site, bring the tube, routine transport for prompt replacement; no forcing

Stridor, voice change or wheeze means an airway foreign body (bls-cpr-choking). Button batteries need emergent endoscopy.

CHILDREN

CONDITION	CLUES	ACTION
Malrotation with volvulus	Green (bilious) vomiting in an infant, even with a soft belly	Emergency: pediatric surgery and imaging now
Incarcerated hernia	Firm, tender groin lump that will not go back; vomiting; red skin	Nothing by mouth, no forced reduction, pediatric surgery
HUS	Bloody diarrhea 5-10 days before; pallor, little urine, edema, high BP	No routine boluses, no NSAIDs or loperamide; center that dialyzes children; ECG

GENITOURINARY AND GYNECOLOGIC

CONDITION	CLUES	ACTION
Renal colic	Waves of flank pain to the groin, restless, hematuria	Ketorolac or an opioid, antiemetic; older: think aorta first
Infected obstructing stone	Fever or rigors behind a known stone	Sepsis care; hospital that can decompress the kidney
Testicular torsion	Sudden pain, high horizontal testis, no cremasteric reflex	Analgesia, urology now: salvage falls to near zero by 12 h
Ovarian torsion	Sudden one-sided pelvic pain with vomiting; ovarian cyst	Exclude ectopic; immediate gynecologic surgery
Urinary retention	No urine, tender suprapubic mass; BPH; new cold tablet	Antihistamines and decongestants trigger it; analgesia, hospital drains the bladder
Heavy menstrual bleeding	Fibroids, a pad an hour, syncope	Shock care: supine, warm, large-bore IV, nothing into the vagina

THE DIALYSIS PATIENT

PROBLEM	CLUES	ACTION
Fistula or graft bleeding	Needle site reopened, arterial flow	Direct pressure on the needle site, firm but not excessive (5-10 min); no tight wrap of the whole fistula; tourniquet only if life-threatening
Hypotension after a run	Dizzy, low BP, clear lungs	Supine, legs up, one measured bolus, reassess lungs; look for sepsis, ischemia, bleeding
Disequilibrium	First sessions; headache, vomiting, then confusion or seizure	Stop dialysis, seizure care ready, ED for cerebral edema
Missed sessions	Weak, confused, asterixis; crackles; wide QRS or peaked T	Uremia, overload, high K: monitor, CPAP, calcium; dialysis-capable hospital
Peritoneal dialysis peritonitis	Cloudy effluent, abdominal pain, fever	Leave the catheter closed; bring the bag

EXAM TIP Protect the access arm: no BP cuff, IV or tourniquet there unless life depends on it. A lost thrill (vibration) suggests a clot: report it.

Sources (44) are listed with links at medicbasics.com/sheets/abdomen-gu-dialysis.html. For education and exam preparation only. Not medical advice; follow current guidelines and your institution's protocols. Medic Basics is an independent study aid not affiliated with any certifying body.