

## Palpation of the abdomen

Mr. D was admitted in the hospital after feeling a severe abdominal and back pain. During the diagnosis, the doctor found that the patient had aortic aneurism, which required an emergency AAA Repair. During the palpation, the patient was positioned supine with his knees supported. The doctor took the history, performed inspection, and auscultation before palpation. This process was critical since it makes the patient feel at ease and cooperates with the physician. The palpation was critical for the process since it stimulates bowel activity before auscultation. Once the physician understands the areas of great pain, he should assure the patient he would minimize the discomfort. The practitioner will reflect on the palpation of the abdomen by adapting Gibb's model of the reflective cycle. The reflection is going to reflect on the palpation of the abdomen at the hospital setting. The practitioner explores the condition diagnosis, involvement, conceptualization and the conclusion regarding the palpation of the abdomen in the case of ruptured aortic neurism. This will be achieved by examining the journal articles such as "Palpating for abdominal aortic aneurysms within a specialist podiatrist and nurse-led peripheral arterial disease service: a pulse too far?" by Fox et al. 2014 and "Incidence, Treatment and Mortality in Patients with Abdominal Aortic Aneurysms: An Analysis of Hospital Discharge Data from 2005–2014" by Kuhn et al. 2017.

Palpation of the abdomen is a crucial component of physical examination of the abdomen. Fox et al. (2014) assert that before palpation, it is important to carry out a predetermined sequence of observation and prepare the patient for the process. Based on the history obtained from the patient, the clinician should have a specific objective in mind. This is because the condition such as abdominal aortic aneurysm (AAA) might not require the clinicians to handle any other issues aside. Kuhn et al. (2017) argues that performing focused examination for AAA patient enables the clinician to identify the etiology of abdominal pain. Once the clinician identifies the problem, he/she may decide to subdivide them into somatoparietal and visceral or referred. Marieb and Hoehn (2010) take a different dimension asserting that although abdominal examination forms a fundamental part of AAA diagnosis and evaluation, it should be minimized in the modern medicine. This is because many of the experts in the pediatric and adult gastroenterology do not emphasize on the abdominal examination. Thus, Marieb and Hoehn (2010) propose that cope's classic will be excellent method to examine the acute abdomen. The review carried out by AlObaidy et al. (2015) in 2016 found that apart from palpation of the abdomen in the cases of AAA, the clinicians supplement the examination through high-resolution imaging techniques. However, this can cause consequences on the patient.

The palpation of abdomen is the crucial method for diagnosing the AAA according to Fox et al. (2014). The authors believe that palpating the abdomen for enlarged pulsating mass of 3 cm is correct. However, there is a debate whereby some authors believe the normal pulse is between 3 cm and 4 cm. AlObaidy et al. (2015) argue that palpation of the abdomen is difficult to perform based on the fact the patient might be experiencing excessive adipose tissue. The risk of rupture associates with the diameter of AAA. This is because it is difficult to determine the average pulse width during medication. Fox et al. (2014) is optimistic that a combination of palpation of the abdomen with other methods such as traditional radiographs

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and ultrasound will produce 90 to 95% accurate results as well as lower the cost. The CT Scanning can be used to determine the shape and the size of aneurysm and progression of AAA. This helps the clinicians to carry out the correct diagnosis. In this case, Mr. D was diagnosed with ruptured aortic aneurysm. It was critical for the clinician to determine the causes of the rupture. Pafili et al. (2015) cite that the causes of the AAA are vasculitis, cystic medial necrosis, congenital vascular disease, and post-surgical anastomotic. Therefore, it was necessary for the clinician to use palpation of the abdomen to determine the cause, which aid in treatment. According to Biglino et al. (2017), more than 20% of people showing the symptoms of AAA have been wrongly diagnosed. This implies that if the patient complains of back pain or fatigue, the medical practitioner should not make the conclusion of the patient having AAA.

The systemic involvement includes the circulatory system, neurologic, integumentary, and respiratory system. Stuntz (2015) argues that AAA affects the blood circulation since the blood pools around distended area. As a result, it decreases the efficiency of blood pump to the lower extremities. Biglino et al. (2017) note that palpation of the abdomen reveals that during the AAA decreases distal pulses. As a result, the patient experiences lower temperature and fluctuation of diastolic blood pressure between the arms. It is expected that the patient will be showing numbness and pain around the lower back, shoulder, and the neck. Pafili et al. (2015) point out that if the patient shows increased pressure around the vital organs, the clinicians should recommend for surgery. This justifies why the practitioner took Mr. D to the theatre for emergency AAA Repair. After the AAA repair, the patient should be allowed to rest for sometimes. Fox et al. (2014) argue that after repair, the incisional pain hinders the function of the abdominal muscles which is fundamental in effective huffing. Coughing is also a dangerous process affecting the healing of the patient, which in the medium-term increases the risk for pulmonary complication. According to Kühnl et al. (2017), the surgeons should not repair aneurysms until they are 43mm. In fact AlObaidy et al. (2015) argue that the diameter of aneurysms should be 55mm. the authors agree that if the surgeons wait until aneurysms is between 45mm and 55mm, the operative mortality will reduce by 5% and the complication cases by 35%.

The palpation of the abdomen can be done successfully by considering the size of the patient. Biglino et al. (2017) assert that in thin people, the health practitioners can feel the abdominal pulse easily. Thus, the detection of AAA depends on the patient's girth and the size of the aneurysm. If the size of the patient goes beyond 100 cm, it will be difficult to practice palpation. That is why if the patient is obese, there is need to include other diagnostic methods such as ultrasound. Stuntz (2015) argues that there are risk factors portrayed by the patient forcing the clinician to use screening palpation. This implies that the clinicians should be keen to choose which method to use before carrying out AAA diagnosis.

In conclusion, Mr. D depicted the symptoms associated with AAA. It was important if the practitioner examines the patient and determines if there are any risk factors. That is, if he/she knows of any risk factor, it will be easy to determine whether the palpation of the abdomen is enough to address the condition. However, with the information provided, it is difficult to conclude the extreme of the AAA effect. The pre-operative examination will enable the

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practitioner eliminate or reduce the cardiovascular risk factor as well as determine the AAA diameter.