Abdominal Pain Scenario:

A 42 year-old male presents to the emergency room with abdominal pain.

Using the Epi-logical approach, what should be the probable diagnoses?
The clinician must consider all probable diagnoses, although diagnoses which are more common in much younger and older population, such as appendicitis and ischemic colitis / mesenteric angina, are less likely. In addition, certain diagnoses such as IBS and gall bladder pathology are more common in women, but they can occur in men as well.
How should a clinician address urgent/emergent situations?
The patient appears uncomfortable, holding the lower part of his abdomen, and his vital signs are within normal range except for slightly elevated temperature of 99 F. Although the patient has relatively normal and hemodynamically stable vital signs, he appears distressed. Therefore, the clinician should be on high alert and keep a low threshold for intervening to avoid a life-threatening situation.
Weighing and Removing Anchor Bias:
The clinician proceeds with asking high yield questions to narrow the differentials and then asks medium yield questions.

The Clinician's Questions	**The Patient's Responses**	**How does this information help with the weighing process?**
Where exactly is your pain?	It is right here. The patient places his hand all over his lower abdomen.	Diagnoses associated with generalized and lower quadrants are more likely. Diagnoses associated with upper quadrants and mid abdominal pain are less likely.
When did your pain start?	It started Monday (today is Wednesday)	Diagnoses presenting with acute pain are more likely than diagnoses causing chronic pain, although certain chronic conditions can flare up as acute pain.
This information leaves the clinician with gastroenteritis, diverticulitis, intestinal obstruction, appendicitis and ischemic colitis as likely diagnoses. Among these, appendicitis and ischemic colitis are less likely in this group. The clinician should also consider constipation, IBD, and IBS, in case these are presenting as flare ups. The clinician can ask additional questions about salient features pertinent to these diagnoses.		
Do you have any nausea, vomiting or diarrhea?	Yes, my stomach is queasy. I feel nauseous, but no vomiting, and have had several episodes of diarrhea over the last couple of days.	Constipation and intestinal obstruction are unlikely. The remaining diagnoses have similar likelihoods as before.

How many bowel movements have you had per day? Did you notice any blood in diarrhea?	I think about 5-8 loose stools per day, and I did not see any blood, but I didn't look every time.	This information does not further differentiate among diagnoses, but it is good to ask these questions to make sure that what the patient has the same understanding of diarrhea.
Did you notice any fever?	I feel warm, but not sure.	The subjective feeling of fever and low-grade temperature at the office make gastroenteritis and diverticulitis likely, and IBS unlikely. IBD is also possible, but the absence of blood makes it less likely, especially if the patient has never had these episodes in the past.
Do you recall eating anything unusual before this started?	No. I ate my regular home cooked meal in the morning, and this started in the afternoon.	There is no change in likelihood of diagnoses currently being considered.
Has anything like this happened before?	Yes, I have had similar episodes in the past, but this is more severe.	Diverticulitis episodes can recur, but so can gastroenteritis.
At this point, the clinician can narrow the differential diagnoses to diverticulitis and gastroenteritis, with diverticulitis being more likely. The clinician can perform a physical exam and gather additional data.		
General and HEENT	Normal	
Abdominal exam	Left lower quadrant tenderness. Normal bowel sounds. Normal liver span. No organomegaly. Rectal exam not done.	Diverticulitis is slightly more likely.

Labs and tests indicated in this situation are a complete blood count, a comprehensive metabolic panel, and a stool test for leukocytes, blood, and fecal calprotectin. The labs show a slightly elevated white blood count, normal metabolic panel, negative for fecal leukocytes and occult blood, and slightly elevated fecal calprotectin, which indicates a need for imaging. The CT scan is consistent with acute diverticulitis, which is the final diagnosis.