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Covid-19 may present with acute abdominal pain

Editor

Coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is typically characterized by respiratory tract symptoms and fever¹. Less focus has been on abdominal pain. There are however some reports on COVID-19 presenting similar to pancreatitis². In our experience, patients have presented with abdominal pain as a main complaint without having findings of abdominal disease, but Covid-19 infection.

We conducted a retrospective analysis of medical records of patients over the age of 18 years admitted to our department between 17 March and 1 April 2020 due to acute abdominal pain. Patients who were diagnosed with

COVID-19 during diagnostic work-up were included. All patients underwent routine screening for COVID-19 before entering hospital. Patients with suspected COVID-19 were isolated and tested for SARS-CoV-2.

In total, 76 patients were admitted with acute abdominal pain as their main complaint. Nine patients (11.8 per cent) were diagnosed with COVID-19 and were included in this study. Median age (range) was 48 (31–81) years. Patient findings from the work-up are shown in Table 1. Following a positive COVID-19 test, patients were re-evaluated for respiratory tract symptoms, which they denied having experienced. In five patients, suspicion of COVID-19 was made from pulmonary findings on acute CT performed for abdominal symptoms. All five subsequently tested positive for SARS-CoV-2. The remaining four patients were diagnosed directly using reverse-transcription polymer chain reaction on oro- and nasopharyngeal swabs. Six patients had no findings on abdominal CT while showing typical findings of COVID-19 on chest CT. All patients were discharged to self-isolation at home. No patient needed ICU treatment.

Although causal relationship between SARS-CoV-2 and abdominal pain cannot be deduced from our limited observations, findings indicate that COVID-19 can present with abdominal pain without respiratory symptoms. A potential explanation could be the presence of cellular angiotensin-converting enzyme 2 (ACE2) in several abdominal organs³, making them susceptible to viral infection as SARS-CoV-2 binds to ACE2⁴.

In the initial phase of the pandemic, our screening criteria for COVID-19 did not include symptoms of abdominal pain. Several patients were first isolated and tested after CT raised suspicion, forcing numerous health professionals into quarantine. CT is performed in the acute setting for these patients and may identify those with unestablished COVID-19 early. However, since three of nine chest CTs were negative, our limited data indicate a low sensitivity for CT as a screening tool for COVID-19.


There are several recommendations on safe practice to reduce the risk of infection during surgery^{2,5}, however abdominal pain as a symptom in acute surgical patients is not discussed in detail. From our limited experience, we believe awareness of acute abdominal

Table 1 Clinical, laboratory and radiologic data from nine patients with acute abdominal pain diagnosed with COVID-19

Patient	Abdominal pain region	Other GI symptoms	Fever	O ₂ saturation (%)	C-reactive protein (mg/l)	White blood cell count ($\times 10^9/l$)	CT		Follow-up (days)
							Abdomen	Chest	
1	Epigastric	Nausea, vomiting	No	94	67	3.4	Normal	Bilateral ground-glass opacities	18
2	Epigastric	Nausea, vomiting	Yes	95	123	4.3	Normal	Bilateral ground-glass opacities	17
3	Global	Nausea	Yes	95	140	7.2	Normal	Bilateral ground-glass opacities	17
4	Left iliac fossa	Nausea, vomiting	Yes	94	111	7.4	Normal	Unilateral ground-glass opacities	16
5	Right iliac fossa	Nausea	Yes	97	43	7.6	Normal	Bilateral ground-glass opacities	21
6	Global	Nausea, vomiting	No	97	7.7	2.6	Normal	Bilateral ground-glass opacities	9
7	Right iliac fossa	Nausea, vomiting	No	90	350	23.8	Cholecystitis	Normal	8
8	Right iliac fossa	Diarrhoea	Yes	100	82	4.6	Appendicitis	Normal	9
9	Umbilical	Nausea	No	99	<0.6	7.7	Ileus	Normal	12

GI, gastrointestinal.

pain as a potential symptom of COVID-19 could reduce the risk of viral transmission to healthcare providers and spread of the infection within hospitals. Modifications have been made to our institutional protocols for acute admission and diagnostic work-up of patients with abdominal pain during the pandemic⁶. Droplet isolation and testing for COVID-19 are now performed on all patients with upper abdominal pain, all patients with abdominal pain (irrespective of location) and fever, and all patients presenting with abdominal pain during quarantine. CT of the chest is performed routinely in all adults undergoing CT of the abdomen for acute abdominal pain.

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European Colorectal Congress

28 November – 1 December 2022, St.Gallen, Switzerland

Monday, 28 November 2022

09.50
Opening and welcome
Jochen Lange, St.Gallen, CH

10.00
It is leaking! Approaches to salvaging an anastomosis
Willem Bemelman, Amsterdam, NL

10.30
Predictive and diagnostic markers of anastomotic leak
Andre D'Hoore, Leuven, BE

11.00
SATELLITE SYMPOSIUM
ETHICON
PART OF THE Johnson & Johnson FAMILY OF COMPANIES

11.45
Of microbes and men – the unspoken story of anastomotic leakage
James Kinross, London, UK

12.15
LUNCH

13.45
Operative techniques to reduce anastomotic recurrence in Crohn's disease
Laura Hancock, Manchester, UK

14.15
Innovative approaches in the treatment of complex Crohn Diseases perianal fistula
Christianne Buskens, Amsterdam, NL

14.45
To divert or not to divert in Crohn surgery – technical aspects and patient factors
Pär Myrelid, Linköping, SE

15.15
COFFEE BREAK

15.45
Appendiceal neoplasia – when to opt for a minimal approach, when and how to go for a maximal treatment
Tom Cecil, Basingstoke, Hampshire, UK

16.15
SATELLITE SYMPOSIUM
Medtronic
Further.Together

17.00
Outcomes of modern induction therapies and Wait and Watch strategies, Hope or Hype
Antonino Spinelli, Milano, IT

17.30
EAES Presidential Lecture - Use of ICG in colorectal surgery: beyond bowel perfusion
Salvador Morales-Conde, Sevilla, ES



18.00
Get-Together with your colleagues
Industrial Exhibition

Tuesday, 29 November 2022

9.00
CONSULTANT'S CORNER
Michel Adamina, Winterthur, CH

10.30
COFFEE BREAK

11.00
SATELLITE SYMPOSIUM
INTUITIVE

11.45
Trends in colorectal oncology and clinical insights for the near future
Rob Glynn-Jones, London, UK

12.15
LUNCH

13.45
VIDEO SESSION

14.15
SATELLITE SYMPOSIUM
BD

15.00
COFFEE BREAK

15.30
The unsolved issue of TME: open, robotic, transanal, or laparoscopic – shining light on evidence and practice
Des Winter, Dublin, IE
Jim Khan, London, UK
Brendan Moran, Basingstoke, UK

16.30
SATELLITE SYMPOSIUM
Takeda



17.15
Lars Pahlman lecture
Søren Laurberg, Aarhus, DK

Thursday, 1 December 2022
Masterclass in Colorectal Surgery
Proctology Day

Wednesday, 30 November 2022

9.00
Advanced risk stratification in colorectal cancer – choosing wisely surgery and adjuvant therapy
Philip Quirke, Leeds, UK

09.30
Predictors for Postoperative Complications and Mortality
Ronan O'Connell, Dublin, IE

10.00
Segmental colectomy versus extended colectomy for complex cancer
Quentin Denost, Bordeaux, FR

10.30
COFFEE BREAK

11.00
Incidental cancer in polyp - completion surgery or endoscopy treatment alone?
Laura Beyer-Berjot, Marseille, FR

11.30
SATELLITE SYMPOSIUM

12.00
Less is more – pushing the boundaries of full-thickness rectal resection
Xavier Serra-Aracil, Barcelona, ES

12.30
LUNCH

14.00
Management of intestinal neuroendocrine neoplasia
Frédéric Ris, Geneva, CH

14.30
Poster Presentation & Best Poster Award
Michel Adamina, Winterthur, CH

15.00
SATELLITE SYMPOSIUM
OLYMPUS

15.45
COFFEE BREAK

16.15
Reoperative pelvic floor surgery – dealing with perineal hernia, reoperations, and complex reconstructions
Guillaume Meurette, Nantes, FR

16.45
Salvage strategies for rectal neoplasia
Roel Hompes, Amsterdam, NL

17.15
Beyond TME – technique and results of pelvic exenteration and sacrectomy
Paris Tekkis, London, UK

19.30
FESTIVE EVENING

Information & Registration www.colorectalsurgery.eu