

Acute Abdominal Pain in Young Versus Elderly Patients: A Comparative Prospective Study of Clinical Presentation, Aetiology, and Management Outcomes

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ABSTRACT

Background: Acute abdominal pain is a common emergency presentation. Clinical features, aetiology, and outcomes differ markedly between young and elderly patients.

Objectives: To compare presentation, diagnosis, management, and outcomes of acute abdominal pain between young (<60 years) and elderly (≥60 years) patients.

Patients and Methods: A prospective study of 193 patients at Al-Hussain Teaching Hospital, Nasiriyah, Iraq (January–November 2024). Group A: young (<60 years, n=139); Group B: elderly (≥60 years, n=54).

Results: Acute appendicitis predominated in young patients (51.80% vs. 16.67%, $p<0.001$). Perforated duodenal ulcer (27.78% vs. 7.19%, $p=0.018$) and intestinal obstruction (24.07% vs. 4.32%, $p<0.001$) were more frequent in the elderly. Young patients more often had tenderness, right iliac fossa pain, and rigid abdomen, while constipation and distension were commoner in elderly patients. Appendectomy was performed more in young patients (51.80% vs. 11.11%, $p<0.001$); conservative management predominated in the elderly (72.22% vs. 33.09%, $p<0.001$). UTI complications were significantly higher in elderly patients (9.26% vs. 0.72%, $p=0.012$).

Conclusions: Elderly patients present atypically with higher rates of serious pathology and postoperative complications. Age-stratified protocols are essential to optimize outcomes.

Keywords: Acute abdominal pain; elderly; Appendicitis; Intestinal obstruction; Perforated Duodenal ulcer; Emergency Surgery; Age Comparison.

1. Introduction

Acute abdominal pain is one of the most frequent causes of emergency department visits and a leading indication for emergency surgical admission worldwide.[1] Although many patients have self-limiting conditions, a significant subset harbour serious intra-abdominal pathology requiring urgent intervention the so-called “acute abdomen.” The severity of pain does not always reflect the gravity of the underlying disease, and early distinction between conditions requiring urgent surgery and those amenable to

conservative management is of paramount importance [1,2]. The aetiological spectrum of acute abdominal pain varies considerably with age. Acute appendicitis is the most common surgical emergency in young adults, with a lifetime risk of appendectomy of approximately 8.6% in males and 6.7% in females, reaching peak incidence in the second and third decades [2]. Age-specific conditions in younger patients also include ovarian cyst complications, ectopic pregnancy, pelvic inflammatory disease, and testicular torsion [3,4]. In contrast, elderly patients are disproportionately affected by perforated peptic ulcer disease, intestinal obstruction, acute cholecystitis, diverticulitis, and mesenteric ischaemia all of which carry substantially higher morbidity and mortality in this population [5].

The diagnostic workup of acute abdominal pain in the elderly is complicated by several factors. The classic triad of fever, localised tenderness, and leukocytosis is frequently absent even in the presence of severe pathology. [5] In elderly patients with acute appendicitis, for example, only 20% present with the full classic triad, and the perforation rate reaches 37% compared with 4% in younger patients. [5] Furthermore, multiple comorbidities and polypharmacy particularly non-steroidal anti-inflammatory drugs, which can mask pain and permit silent ulcer perforation contribute to diagnostic delay and worse outcomes [6]. Physical examination remains central to the assessment of acute abdominal pain. Specific manoeuvres including Murphy's sign for cholecystitis, the psoas sign for appendicitis, and Carnett's sign for abdominal wall pain guide the differential diagnosis, while peritoneal signs such as localised tenderness, rebound tenderness, and involuntary guarding are highly indicative of a surgical abdomen and mandate urgent surgical consultation [7].

Radiological investigations, particularly computed tomography (CT), are now considered the standard of care in equivocal cases across all age groups [5]. Management is also age-dependent. Appendectomy carries low operative risk in young patients and remains the mainstay of treatment for acute appendicitis in this group [8]. In elderly patients, surgical risk is substantially elevated due to comorbidities and reduced physiological reserve, and conservative or minimally invasive approaches are favoured where clinically appropriate [9,10]. This age-related divergence in presentation and management strategy necessitates a tailored, age-conscious approach to the acute abdomen. Despite the importance of age as a determinant of presentation and outcome, comparative prospective data from southern Iraq remain scarce. The present study was therefore designed to prospectively compare the clinical presentation, aetiological distribution, management strategies, and postoperative outcomes of acute abdominal pain between young and elderly patients presenting to a surgical emergency department in Nasiriyah, Iraq.

2. PATIENTS AND METHODS

2.1. Study Design and Setting

This prospective single-centre study was conducted at the Surgical Emergency Department of Al-Hussain Teaching Hospital, Nasiriyah, Dhi Qar, Iraq, from January to November 2024. Ethical approval was granted by the Iraqi Board of Medical Specialization. Written informed consent was obtained from all participants prior to enrolment.

2.2. Study Population

A total of 193 consecutive patients presenting with acute abdominal pain were enrolled. Eligible patients were classified according to the WHO/UN age definition [11] into Group A (young): age <60 years

(n=139), and Group B (elderly): age ≥ 60 years (n=54). Patients younger than 16 years, those presenting with abdominal trauma, and those who declined to participate were excluded.

2.3. Patient Evaluation and Data Collection

All patients underwent systematic evaluation including resuscitation as required, detailed history taking, and physical examination (abdominal movement with respiration, tenderness, rebound tenderness, guarding, rigidity, bowel sounds, and digital rectal examination). Investigations included chest and abdominal X-rays, abdominal ultrasonography, and CT scan where indicated. Demographic data, comorbidities, duration of pain, clinical presentation, primary diagnosis, management strategy, hospital stay, and complications were recorded.

2.4. Statistical Analysis

Data were analysed using SPSS version 25.0. Continuous variables were expressed as mean \pm SD and compared with the independent samples t-test. Categorical variables were expressed as frequencies and percentages and compared with the chi-square or Fisher's exact test. A p-value < 0.05 was considered statistically significant.

3. RESULTS

3.1 Overall Patient Characteristics

The 193 enrolled patients had a mean age of 39.24 ± 17.12 years (range: 11–80). Females accounted for 52.33% of the cohort. Hypertension was the most common comorbidity (19.69%), followed by diabetes mellitus (16.58%) and malignancy (9.33%). The mean pain duration was 3.51 ± 1.64 days. Nausea and tenderness were the most prevalent symptoms (75.65% and 75.13%, respectively). Acute appendicitis was the leading diagnosis (41.97%), followed by perforated duodenal ulcer (12.44%), cholecystitis (10.36%), and intestinal obstruction (9.84%). Mean hospital stay was 2.44 ± 1.83 days.

3.2 Age Group Distribution and Demographic Comparison

Young patients (< 60 years) comprised 72% (n=139) and elderly patients (≥ 60 years) comprised 28% (n=54). Sex distribution was comparable between groups (p=0.934). Retired individuals predominated among the elderly (29.63% vs. 1.44%), while free workers and students were more prevalent in the young (p < 0.001). Smoking was significantly more common in elderly patients (24.07% vs. 10.79%, p=0.019). Comorbidities including diabetes mellitus, IHD, CVA, ACS, and pulmonary disease were all significantly more prevalent in the elderly (Table 1).

Table 1. Demographic and comorbidity characteristics by age group

Variable	Young (n=139)	Elderly (n=54)	p-value
Age, years (Mean \pm SD)	30.24 \pm 8.97	63.48 \pm 4.07	<0.001
Male sex, n (%)	66 (47.48%)	26 (48.15%)	0.934
Ex/current smoker, n (%)	15 (10.79%)	13 (24.07%)	0.019
Diabetes mellitus, n (%)	18 (12.95%)	14 (25.93%)	0.030
Hypertension, n (%)	22 (15.83%)	16 (11.51%)	0.213
Ischaemic heart disease, n (%)	7 (5.04%)	8 (14.81%)	0.023
CVA, n (%)	3 (2.16%)	10 (18.52%)	<0.001
Pulmonary disease, n (%)	2 (1.44%)	4 (7.41%)	0.007

3.3 Clinical Presentation by Age Group

Young patients more commonly exhibited tenderness (79.86% vs. 62.96%, $p=0.015$), right iliac fossa (RIF) pain (56.12% vs. 35.19%, $p=0.009$), and rigid abdomen (41.01% vs. 24.07%, $p=0.028$). Constipation (18.52% vs. 6.47%, $p=0.012$) and abdominal distension (16.67% vs. 6.47%, $p=0.029$) were significantly more common in elderly patients. Fever, nausea, vomiting, and rebound tenderness did not differ significantly between groups. Mean pain duration was comparable (3.46 ± 1.54 vs. 3.70 ± 1.80 days, $p=0.428$). Clinical findings are summarised in Table 2.

Table 2. Comparison of clinical presentation between age groups

Clinical Feature	Young (n=139)	Elderly (n=54)	p-value
Fever, n (%)	93 (66.91%)	41 (75.93%)	0.222
Nausea, n (%)	107 (76.98%)	39 (72.22%)	0.490
Vomiting, n (%)	94 (67.63%)	35 (64.81%)	0.710
Tenderness, n (%)	111 (79.86%)	34 (62.96%)	0.015
RIF pain, n (%)	78 (56.12%)	19 (35.19%)	0.009
Rigid abdomen, n (%)	57 (41.01%)	13 (24.07%)	0.028
Rebound tenderness, n (%)	91 (65.47%)	39 (72.22%)	0.369
Constipation, n (%)	9 (6.47%)	10 (18.52%)	0.012
Abdominal distension, n (%)	9 (6.47%)	9 (16.67%)	0.029

3.4 Aetiological Distribution by Age Group

The distribution of diagnoses differed markedly between groups (Table 3). Acute appendicitis was the predominant cause in young patients (51.80%) but significantly less frequent in the elderly (16.67%, $p<0.001$). Perforated duodenal ulcer (27.78% vs. 7.19%, $p=0.018$) and intestinal obstruction (24.07% vs. 4.32%, $p<0.001$) were significantly more common in elderly patients.

Cholecystitis and ovarian cyst complications showed no significant age-related difference ($p=0.234$ each). Rare diagnoses including mesenteric ischaemia, diverticulitis, ruptured uterus, and abdominal aortic aneurysm were observed at comparable rates (2.88% vs. 3.56%, $p=0.817$).

Table 3. Aetiological distribution of acute abdominal pain by age group

Diagnosis	Young (n=139)	Elderly (n=54)	p-value
Acute appendicitis	72 (51.80%)	9 (16.67%)	<0.001
Perforated duodenal ulcer	10 (7.19%)	15 (27.78%)	0.018
Intestinal obstruction	6 (4.32%)	13 (24.07%)	<0.001
Cholecystitis	16 (11.51%)	4 (7.41%)	0.234
Ovarian cyst complication	16 (11.51%)	4 (7.41%)	0.234
Urinary tract infection	5 (3.60%)	2 (3.70%)	0.989
Renal stone	5 (3.60%)	1 (1.85%)	0.645
Ectopic pregnancy	3 (2.16%)	1 (1.85%)	0.745
Acute pancreatitis	2 (1.44%)	3 (5.56%)	0.343
Other causes*	4 (2.88%)	3 (3.56%)	0.817

* Other causes: 3 mesenteric ischaemia, 2 diverticulitis, 1 ruptured uterus, 1 abdominal aortic aneurysm.

3.5 Management and Outcomes by Age Group

Appendectomy was performed in 51.80% of young versus 11.11% of elderly patients ($p<0.001$). Conservative management predominated in the elderly (72.22% vs. 33.09%, $p<0.001$). Exploratory laparotomy rates were comparable (15.11% vs. 16.67%, $p=0.876$).

The overall complication rate was significantly higher in the elderly, with only 64.81% of elderly patients free of complications compared to 88.49% of young patients ($p=0.043$). UTI was the only complication to reach statistical significance (9.26% vs. 0.72%, $p=0.012$). Mortality was 7.41% in elderly versus 2.16% in young patients ($p=0.421$). These findings are summarised in Table 4.

Table 4. Management strategies and outcomes by age group

Variable	Young (n=139)	Elderly (n=54)	p-value
Appendectomy, n (%)	72 (51.80%)	6 (11.11%)	<0.001
Conservative management, n (%)	46 (33.09%)	39 (72.22%)	<0.001
Exploratory laparotomy, n (%)	21 (15.11%)	9 (16.67%)	0.876
No complications, n (%)	123 (88.49%)	35 (64.81%)	0.043
Surgical site infection, n (%)	5 (3.60%)	5 (9.26%)	0.211
Abdominal collection, n (%)	6 (4.32%)	2 (3.70%)	0.756
Pulmonary embolism, n (%)	4 (2.88%)	4 (7.41%)	0.118
Urinary tract infection, n (%)	1 (0.72%)	5 (9.26%)	0.012
Hospital stay, days (Mean±SD)	2.35±1.88	2.82±1.93	0.197
Mortality, n (%)	3 (2.16%)	4 (7.41%)	0.421

4. DISCUSSION

This prospective study compared the clinical presentation, aetiological spectrum, and management outcomes of acute abdominal pain in 193 patients stratified by age. The mean age was 39.24 years, with females comprising 52.33% of the cohort, consistent with studies reporting a slightly higher prevalence of acute abdominal conditions in females, partly attributable to gynaecological causes such as ovarian cyst complications and ectopic pregnancy [12].

Acute appendicitis was the leading diagnosis overall (41.97%) and the dominant cause in young patients (51.80%), consistent with global patterns.[8] Cervellin et al., in a large Italian series of 5,340 ED presentations, similarly identified appendicitis as the leading urgent aetiology.[13] An Iraqi study by Abdulla comparing 51 young and 21 elderly patients found acute appendicitis in 36.11%, cholecystitis in 16.67%, and intestinal obstruction in 11.11%, figures broadly comparable to the present series.[14] The higher prevalence of appendicitis in young individuals reflects the anatomical and physiological characteristics of the appendix at this age, including greater lymphoid hyperplasia predisposing to luminal obstruction [15]. Elderly patients were significantly more likely to present with perforated duodenal ulcer (27.78%) and intestinal obstruction (24.07%). Perforated peptic ulcer disease in the elderly is driven by higher NSAID use, H. pylori infection, and reduced mucosal protection; mortality ranges from 12% to 47% and increases substantially beyond age 65.[6] Intestinal obstruction in the elderly is predominantly attributable to colorectal malignancy, adhesions, and sigmoid volvulus, all of which increase with age.[16,17] Martin et al. in a multicentre French study similarly demonstrated that intestinal obstruction was significantly more frequent in elderly than younger patients ($p=0.001$)[18]. The present study confirms the well-documented atypicality of acute abdominal presentation in the elderly. Young patients more frequently exhibited classic features tenderness, RIF pain, and rigid abdomen while elderly

patients more commonly presented with constipation and abdominal distension, consistent with mechanical obstruction or colonic pathology.

Previous reports confirm that elderly patients with appendicitis rarely present with the classic triad [5], and that small bowel obstruction in the elderly presents more subtly and later, leading to higher misdiagnosis rates [19]. Blunting of peritoneal signs due to reduced muscle tone, immunosenescence, and analgesic use further complicates assessment and underscores the importance of early CT evaluation [5,7]. Comorbidities were substantially more prevalent in elderly patients, with significantly higher rates of diabetes mellitus, IHD, CVA, ACS, and pulmonary disease. This pattern, reported by Sanson and O'Keefe [20] and Flasha and Goldberg, [21] reflects the progressive accumulation of chronic disease with age and is a major determinant of operative risk and outcome [22,23]. The higher smoking prevalence in elderly patients is consistent with cohort effects and is associated with increased risk of gastrointestinal complications including peptic ulcer disease [24].

Appendectomy was performed in 51.80% of young patients versus only 11.11% of elderly patients, reflecting both the higher appendicitis prevalence and the elevated operative risk in older patients. [8] Conservative management predominated in the elderly (72.22%), consistent with evidence that non-operative management is increasingly favoured in older patients, though it requires vigilant monitoring to avoid delayed intervention. [9] Exploratory laparotomy rates were comparable between groups (15.11% vs. 16.67%, $p=0.876$). Postoperative complications were more frequent in elderly patients, with only 64.81% free of complications versus 88.49% of young patients ($p=0.043$). UTI was the only complication to reach statistical significance (9.26% vs. 0.72%, $p=0.012$), consistent with the known predisposition of elderly patients to urinary tract infection related to urinary stasis, bladder dysfunction, and comorbid diabetes [25]. Pulmonary embolism was more common in the elderly (7.41% vs. 2.88%), though without statistical significance, likely due to the modest sample size; this trend highlights the importance of prophylactic anticoagulation in elderly patients undergoing conservative or surgical management [26]. The overall mortality was low in both groups (7.41% vs. 2.16%, $p=0.421$), reflecting appropriate perioperative care. Recent advances in surgical technique and critical care have considerably improved survival across all age groups [27,28]. This study has several limitations. The single-centre design limits generalisability, and the relatively modest elderly cohort ($n=54$) may have reduced power to detect between-group differences. Future multicentre prospective studies with larger elderly cohorts and standardised severity scoring tools are warranted.

5. CONCLUSIONS

Acute abdominal pain in elderly patients presents with a distinctly different clinical profile compared with younger patients. Elderly individuals more commonly present with atypical symptoms, harbour more serious underlying pathology including perforated duodenal ulcer and intestinal obstruction, and carry a higher complication burden. Acute appendicitis predominates in young patients and warrants prompt surgical intervention, while conservative management is appropriately favoured in the elderly when clinically safe. Age-stratified diagnostic protocols, early radiological evaluation, and individualised perioperative care are essential to optimise outcomes in all age groups.

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