

# The problem-solving role of the 'wait and repeat CT' approach in the diagnosis and treatment of acute abdomen

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## ABSTRACT

**BACKGROUND:** This study aims to assess the diagnostic value and problem-solving utility of follow-up abdominopelvic computed tomography (CT) scans performed within 10 days of the initial presentation for acute non-traumatic abdominal symptoms in the emergency department.

**METHODS:** A retrospective analysis was conducted on patients who presented with acute abdominal symptoms to the emergency department between January 1, 2013 and May 30, 2023, and underwent abdominopelvic CT scans in the acute setting. Among this cohort, 149 patients had repeat abdominopelvic CT scans during the same admission and were classified into five groups based on findings: Group A (no change in diagnosis), Group B (confirmation of suspected initial diagnosis), Group C (disease progression), Group D (disease regression), and Group E (new diagnosis).

**RESULTS:** The mean age of the cohort was 51.5±18 years (range: 19-92). The average interval between initial and repeat CT scans was 40.9±59.05 hours (range: 0.5-238). The number of patients in each group was as follows: Group A (n=21), Group B (n=60), Group C (n=32), Group D (n=25), and Group E (n=11). Partial bowel obstruction was the most common finding (27%, 41/149), with 72% (18/25) of Group D showing regression on follow-up CT. The "wait and follow-up" approach significantly guided management decisions for partial bowel obstruction ( $p<0.01$ ).

**CONCLUSION:** This study emphasizes the importance of the "wait and repeat CT" strategy in enhancing diagnostic accuracy and guiding clinical management for patients with acute non-traumatic abdominal complaints. Follow-up CT scans were particularly effective in identifying conditions such as partial bowel obstruction.

**Keywords:** Abdominal pain; acute abdomen; computed tomography; emergency medicine; intestinal obstruction.

## INTRODUCTION

In emergency radiology (ER) practice, abdominopelvic CT scans play an indispensable role in the assessment of patients with acute non-traumatic abdominal symptoms. Abdominal pain, one of the most frequent reasons for emergency department visits, is a key indication for CT imaging.<sup>[1]</sup> Ab-

dominopelvic CT has become a cornerstone of routine emergency practice due to its ability to provide rapid and detailed cross-sectional imaging, enabling clinicians to swiftly identify life-threatening conditions and guide treatment decisions.<sup>[2-5]</sup> However, within this patient population, there remains a lack of well-established classification systems and limited research on the clinical utility of repeat abdominopelvic CT scans. Few

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studies in the literature have evaluated the diagnostic contribution of repeat imaging.<sup>[6,7]</sup>

This study aims to address this gap by focusing on patients for whom the "wait and repeat" strategy is employed. Our objective is to identify and characterize the patient subgroup that benefit most from follow-up CT scans, particularly in cases where the initial scan fails to provide a definitive diagnosis. By analyzing the diagnostic value of repeat abdominopelvic CT scans performed within one week of the initial presentation, this study seeks to determine which patient subgroups benefit most from this approach and to define the specific scenarios in which repeat imaging serves as a crucial diagnostic tool.

## MATERIALS AND METHODS

**Study Design and Time Period:** The study protocol was approved by the Institutional Review Board of Hacettepe University Hospital (Approval No: GO 23-566). The study was conducted in accordance with the principles of the Declaration of Helsinki. Patients who presented to the emergency department (ED) at Hacettepe University Hospital between January 1, 2013 and May 30, 2023, with acute abdominal pain and underwent abdominal CT scans were included in this retrospective study.

**Population and Sample Size:** A total of 16,474 patients were admitted to the emergency department with abdominal complaints. Among these patients, 228 underwent repeat abdominal CT examinations during the same admission. After excluding 79 patients for the following reasons: being under 18 years of age (n=12), images with artifacts (n=49), known chronic organic gastrointestinal disease (n=11), or complications of known malignancy (n=7), a total of 149 patients with appropriate CT images were included in the final analysis.

**Study Setting:** CT scans were performed using a 2-slice scanner (until 2016) and a 64-multislice CT scanner (after 2016). The standard protocol for non-traumatic abdominal pain included administering 50 cc of oral contrast (iopamidol-300) diluted in 600 mL of water, consumed one hour prior to the CT scan, and 80 cc of intravenous contrast (iopamidol-370), injected 90 seconds before CT scanning. For CT scans performed with a renal protocol, no intravenous contrast was administered. Images were acquired at 3-mm intervals, spanning from the middle of the heart to the ischial tuberosities, with routine coronal reconstructions performed. The distribution of initial CT examinations according to contrast agent utilization was as follows: 92 scans (61.7%) without intravenous (IV) contrast, 32 scans (21.4%) with only IV contrast, 17 scans (11.4%) with both IV and oral contrast, and 8 scans (5.3%) with only oral contrast. For follow-up CT examinations, the breakdown was: 75 scans (50.3%) with only IV contrast, 31 scans (20.8%) without oral or IV contrast, 26 scans (17.4%) with both IV and oral contrast, and 17 scans (11.4%) with only oral contrast.

**Intervention and Outcome Measures:** Medical records, including CT reports, physician notes, nursing notes, and specialty consultations, were comprehensively reviewed. Vital signs, laboratory test results, and all imaging studies conducted in the ED were also included in the analysis.

Patients were categorized based on the similarity or difference between initial and repeat CT findings into the following groups:

- Group A: No change in preliminary diagnosis on repeat CT.
- Group B: Confirmation of the initially suspected diagnosis.
- Group C: Disease progression after initial diagnosis.
- Group D: Regression of findings after initial diagnosis.
- Group E: Identification of a completely different diagnosis.

## Data Analysis

Continuous variables were summarized as mean  $\pm$  standard deviations or median (range), depending on distributional characteristics. Normality was tested using the Kolmogorov-Smirnov test. Categorical variables were evaluated with the chi-square test or Fisher's exact test, as appropriate. Statistical analyses were performed using IBM SPSS Statistics for Windows, Version 26.0 (IBM Corp., Armonk, NY, USA). A two-tailed  $p < 0.05$  was considered statistically significant.

## RESULTS

This study included 149 patients who met the inclusion criteria: age over 18 years, absence of chronic conditions or known malignancies, and exclusion of cases with image artifacts. The mean age of the cohort was  $51.5 \pm 18$  years, with a median of 53 years (range: 19-92 years). Of the patients, 91 (61.07%) were male and 58 (38.93%) were female. The average interval between the initial and repeat CT scans was  $40.9 \pm 59.05$  hours (range: 0.5-238 hours) (Table 1).

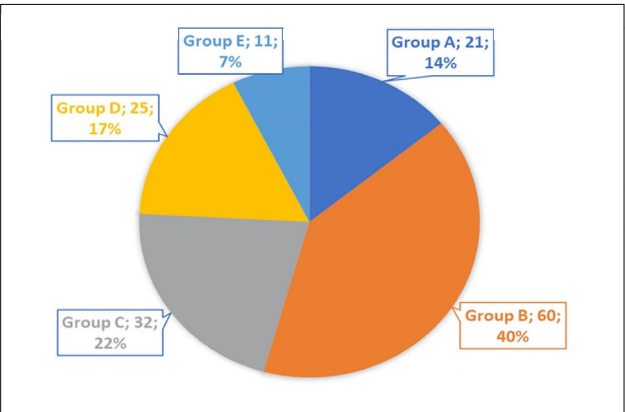
The diagnostic outcomes from the repeat CT scans were classified into five groups based on changes relative to the initial scans (Fig. 1, Fig. 2):

- Group A (No change in the preliminary diagnosis): 21 patients (14%) showed no change in CT findings between the initial and follow-up scans, maintaining the original diagnosis.
- Group B (Confirmation of suspected diagnosis on follow-up CT): 60 patients (40%) had their initial suspected diagnoses confirmed on repeat CT.
- Group C (Disease progression after initial diagnosis): 32 patients (22%) showed progression of findings compared with the initial scan.
- Group D (Disease regression of initial findings on follow-up CT): 25 patients (17%) demonstrated regression of initial findings on repeat CTs.

**Table 1.** Demographic characteristics of patients and contrast agent use in computed tomography (CT) scans

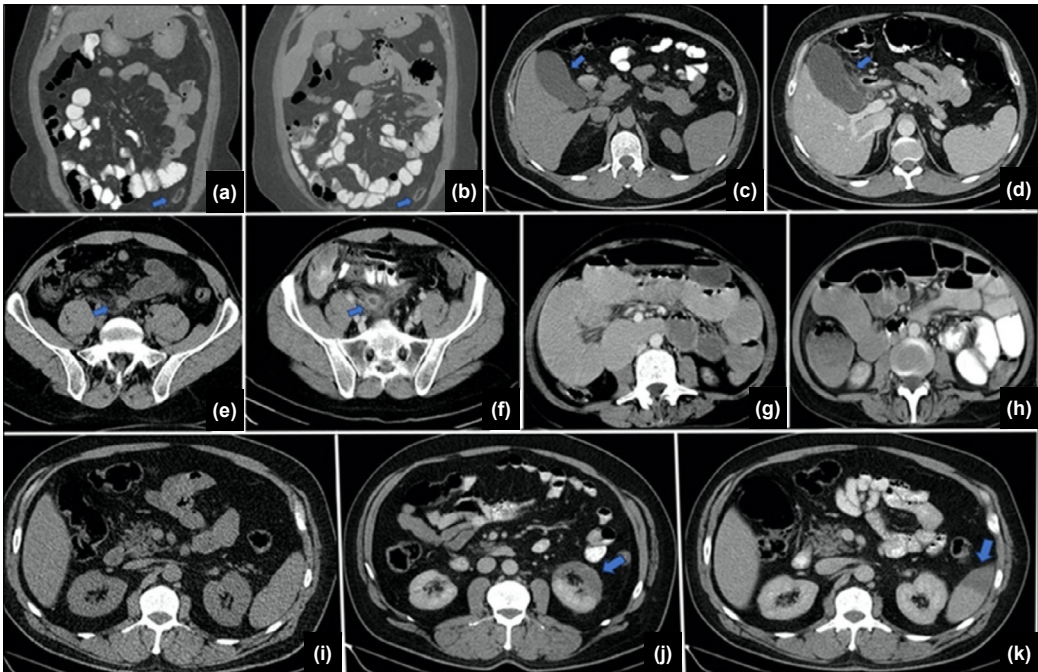
Parameter	Mean±SD or Number
Mean age in years (range)	51.5±18 (19-92)
Number of males/total (%)	91/149 (61.7%)
Mean interval between CT scans (range)	40.9±59.05 (0.5-238)
Initial CT scan (number, percentage)	
Non-contrast	92 (61.7%)
IV contrast	32 (21.4%)
Oral contrast	8 (5.3%)
IV + oral contrast	17 (11.4%)
Repeat CT scan (number, percentage)	
Non-contrast	31 (20.9%)
IV contrast	75 (50.3%)
Oral contrast	17 (11.4%)
IV + oral contrast	6 (17.4%)

• Group E (Completely different diagnosis): 11 patients (7%) were found to have a completely different diagnosis on repeat CT, not suspected during the initial examination.



**Figure 1.** The number and percentage of patients in each group.

In Group A (n=21), the most common diagnoses were urolithiasis (seven patients), epiploic appendagitis (six patients), and partial bowel obstruction (six patients). In Group B (n=60), frequent diagnoses included enterocolitis, partial bowel obstruction, acute appendicitis, acute cholecystitis, pelvic inflammatory disease, acute pyelonephritis, and serositis. In Group C (n=32) predominant diagnoses were partial bowel obstruction, acute appendicitis, urolithiasis, renal infarction, enterocolitis, and acute pyelonephritis. In Group D (25 patients), the most prevalent condition was partial bowel obstruction, followed by enterocolitis, serositis, and urolithiasis. Group E (11 patients) revealed diverse new diagnoses on



**Figure 2.** Representative cases for each group. Group A: No change in findings of epiploic appendicitis located in the left lower quadrant on repeat computed tomography (CT) scan (a, b, arrows). Group B: Initially suspicious findings of acute cholecystitis on the first CT scan were confirmed on follow-up CT (c, d, arrows). Group C: Findings of acute appendicitis showed progress (e, f, arrows). Group D: Findings of partial bowel obstruction improved (g, h). Group E: Initial CT was negative (i), while the follow-up CT revealed renal infarction (j, arrow) and splenic infarction (k, arrow).

**Table 2.** Distribution and frequency of findings across groups, presented as the number of patients in each category. Group sizes are shown in brackets.

Group A (n=21)	Group B (n=60)	Group C (n=32)	Group D (n=25)	Group E (n=11)
Urolithiasis (7)	Enterocolitis (14)	Partial bowel obstruction (8)	Partial bowel obstruction (18)	Renal infarction (5)
Epiploic appendagitis (6)	Partial bowel obstruction (7)	Acute appendicitis (3)	Enterocolitis (4)	Partial bowel obstruction (2)
Partial bowel obstruction (6)	Acute appendicitis (7)	Urolithiasis (3)	Serositis (2)	Acute pancreatitis (1)
Omental infarction (1)	Pelvic inflammatory disease (5)	Renal infarction (2)	Urolithiasis (1)	Cholelithiasis (1)
Acute diverticulitis (1)	Acute cholecystitis (5)	Enterocolitis (2)		Urolithiasis (1)
	Acute pyelonephritis (3)	Acute pyelonephritis (2)		Cystitis (1)
	Serositis (2)	Others (12)		
	Others (17)			

repeat CT, including renal infarction, partial bowel obstruction, acute pancreatitis, cholelithiasis, urolithiasis, and cystitis (Table 2).

In Group A, all six patients diagnosed with epiploic appendagitis initially underwent non-contrast CT imaging. However, due to persistent symptoms, follow-up contrast-enhanced CT scans were subsequently performed. Similarly, among the seven patients with urolithiasis in Group A, six underwent non-contrast CT as their initial imaging modality. Of these, two required contrast-enhanced repeat CT due to anuria, while the remaining patients underwent repeat imaging because of ongoing pain. In Group B (60 patients with confirmed suspected diagnoses on repeat CT), the initial imaging was non-contrast in 48 cases. Of these, 42 underwent repeat CT with IV contrast. In Group E, non-contrast CT was used as the initial imaging modality in 9 of the 11 patients, with contrast-enhanced CT performed during repeat evaluations. In one patient, the initial contrast-enhanced CT scan failed to clearly identify a stone at the ureterovesical junction, which was retrospectively noted to have been difficult to detect. However, the stone was successfully visualized on the follow-up non-contrast CT scan.

The average time interval between the initial and repeat CT scans was  $40.9 \pm 59.05$  hours (range: 0.5-238 hours). When analyzing the intervals for each group individually, the mean durations were: Group A,  $49.3 \pm 59.05$  hours (range: 1-181 hours); Group B,  $30.8 \pm 54.5$  hours (range: 0.5-229 hours); Group C,  $62 \pm 71.2$  hours (range: 1.5-238 hours); Group D,  $28.1 \pm 43.7$  hours (range: 1.5-205 hours); and Group E,  $47.6 \pm 66.6$  hours (range: 1.5-210 hours). The highest average time interval between CTs was observed in Group C. Although no statistically significant differences were identified between the mean time intervals across the groups, the considerable variability in the duration between examinations suggests that direct comparisons may not be appropriate.

A particularly notable finding was the high prevalence of partial bowel obstruction, which was observed in 41 of 149 patients (27%), making it the most frequent condition across all groups. In Group D, 18 of the 25 patients (72%) with partial bowel obstruction experienced regression of findings on repeat CT scans, indicating that many of these patients benefit from the "wait and repeat" approach. Among the 18 patients with partial intestinal obstruction in Group D, obstruction in two cases was attributed to ventral and inguinal hernias and resolved following surgery. The remaining patients were managed conservatively without surgery, using nasogastric tube decompression, during which the obstruction resolved. Oral contrast was administered in the initial CT scan of eight patients, whereas it was used in repeat CT imaging in only five of these patients. In the progression group, the most frequently observed condition was partial intestinal obstruction, affecting eight patients. However, partial bowel obstruction was significantly more prevalent in the regression group compared to other groups ( $p < 0.01$ ), and follow-up CT imaging appeared particularly valuable for both monitoring these patients and informing treatment decisions. Importantly, no patients experienced significant adverse events from either the initial or repeat CT scans, although the potential long-term radiation risks from CT exposure were not directly addressed in this study.

## DISCUSSION

Acute non-traumatic abdominal pain is a frequent presenting complaint in emergency departments and often necessitates abdominopelvic CT scans for accurate diagnosis. Multi-detector CT scanners provide high diagnostic accuracy and play a key role in guiding critical patient management decisions.<sup>[8-11]</sup> In particular, the "wait and repeat CT" strategy has gained attention for its potential to yield additional diagnostic information without requiring immediate surgical intervention.



Our findings demonstrate that the "wait and repeat CT" approach plays a significant role in refining diagnoses and guiding clinical management. By categorizing patients based on changes between initial and follow-up CT findings, we identified several diagnostic outcomes: confirmation of initial suspicions, detection of disease progression, regression of findings, and identification of new diagnoses. This study specifically aimed to evaluate the diagnostic contribution and problem-solving role of repeat CT imaging performed within 10 days for acute non-traumatic abdominal conditions. Through this analysis, we sought to establish the value of follow-up CT in confirming or modifying initial diagnoses, as well as detecting disease changes or previously unrecognized conditions.

Our data also highlight the potential utility of performing contrast-enhanced CT scans following non-contrast imaging in selected clinical scenarios. Among patients with a confirmed suspected diagnosis, the transition from non-contrast to contrast-enhanced CT in 42 of 48 cases improved diagnostic assessment and management, underscoring its importance in refining diagnostic accuracy. Furthermore, in Group E, contrast-enhanced imaging during repeat evaluations was beneficial in many cases. However, findings from one patient suggest that non-contrast imaging may sometimes be more effective, particularly in specific contexts such as identifying stones at the ureterovesical junction. The importance of IV contrast in confirming diagnoses has been demonstrated, particularly in patients whose suspected diagnosis was validated. Performing with IV contrast in these patients, when clinically indicated, may improve diagnostic accuracy while reducing the rate of unnecessary CT scans.

Our findings contribute to the ongoing discussion regarding the diagnostic utility of repeat imaging in acute abdominal cases. Lee et al.<sup>[7]</sup> reported that repeat abdominopelvic CT scans within one month revealed new or worsening findings in 30% of patients presenting to the emergency department with acute abdominal pain, emphasizing the importance of repeat imaging in clinical decision-making. In our study, which used a shorter interval of 10 days compared to their one-month interval, 14% of patients exhibited no change on repeat CT, in contrast to the 43% reported in their study. We observed progression in 22% of patients (Group C) among 149 cases, compared to their study, which reported a progression rate of 15% in 53 patients. Similarly, 17% of our patients showed regression (Group D), compared with 26% in their study. Finally, 7% of our patients were diagnosed with a different condition on repeat CT (Group E), compared to 15% in the same group in their study. These differences may reflect the potential influence of varying time intervals on the outcomes of repeat imaging.

In contrast, Nojkov et al.<sup>[12]</sup> concluded that repeat abdominal CT scans after an initially negative CT in non-traumatic abdominal pain cases had a low diagnostic yield (6.5%). Our findings suggest a different perspective: 14% of patients retained their original diagnosis, 40% had their initial suspected

diagnosis confirmed, 22% demonstrated disease progression, 17% showed regression, and 7% received an entirely new diagnosis. These findings emphasize the higher diagnostic yield of repeat CT in our patient population compared to the results reported by Nojkov et al.<sup>[12]</sup> In their study, the most frequently observed findings were obstructive nephrolithiasis, gastrointestinal mural thickening or masses, and diverticulitis. In contrast, the most common findings in our study were partial bowel obstruction, enterocolitis, urolithiasis, and acute cholecystitis.

The diagnostic utility of follow-up CT scans was particularly notable in cases of partial bowel obstruction, which was the most frequently encountered condition in our study, affecting 27% of patients. Regression of findings on follow-up imaging was observed in 72% of these patients (Group D), supporting the "wait and repeat" approach as a valuable strategy, particularly for managing partial bowel obstruction. Among the patients with partial obstruction who showed regression, no clear underlying cause was identified in most cases, except for two (ventral and inguinal hernias). These cases were managed with nasogastric tube decompression, which led to symptom resolution and was attributed to adhesions. Oral contrast was administered during follow-up CT in only five of these patients. Although no statistically significant benefit ( $p < 0.05$ ) of oral contrast in resolving partial obstruction was observed, the unequal data distribution and small sample size suggest that its impact should be further investigated in larger studies.

This study has several limitations. The retrospective design may introduce selection bias, and the single-center setting in a tertiary-care teaching hospital may limit the generalizability of the findings to smaller community hospitals. Furthermore, the relatively small sample size reduces the robustness of the study, emphasizing the need for future prospective studies to confirm these findings. The small sample size limits the ability to assess the utility of repeat CT imaging for diagnosing rare but potentially fatal conditions that might be overlooked. Large-scale studies using standardized equipment and imaging protocols are needed to validate these findings. The repetition of CT imaging despite unchanged diagnosis highlights a limitation in the use of follow-up imaging. In Group A, all six patients with epiploic appendagitis underwent repeat contrast-enhanced CT scans solely due to persistent symptoms, yet the findings did not alter the initial diagnosis. Similarly, among the six patients with urolithiasis who initially underwent non-contrast CT, repeat imaging with contrast was performed in two cases due to anuria and in the remaining cases for ongoing pain, but the diagnostic outcomes remained unchanged. These observations suggest potential overutilization of repeat imaging in situations where it may not significantly influence clinical decision-making, underscoring the need for more judicious use of follow-up CT scans to balance patient care with resource efficiency. When comparing the mean time intervals between examinations across groups, no statistically significant differences were observed.

However, the considerable variability in these intervals may have introduced selection bias in group formation, representing a potential limitation of the study. Furthermore, imaging performed up to 10 days later may reflect entirely different disease processes, making it impractical to apply a single time frame to the management of conditions with widely varying urgency. Additionally, the heterogeneous use of oral and intravenous contrast agents, the limited imaging phases acquired, and the use of both 2-slice and 64-slice CT scanners may have reduced image quality and consistency, posing another limitation of this study.

## CONCLUSION

Our study highlights the significant diagnostic contribution of repeat abdominopelvic CT scans performed within 10 days in patients with acute non-traumatic abdominal pain. The "wait and repeat" strategy is invaluable for confirming or revising diagnoses, detecting disease progression or regression, and identifying new conditions. Despite ongoing concerns about radiation exposure and economic costs, the clinical benefits, particularly in dynamic conditions such as partial bowel obstruction, support the continued use of this approach. Future research should focus on optimizing imaging protocols to balance diagnostic accuracy with patient safety and cost-effectiveness.

**Ethics Committee Approval:** This study was approved by the Hacettepe University Hospital Ethics Committee (Date: 11.07.2023, Decision No: GO 23-566).

**Peer-review:** Externally peer-reviewed.

**Authorship Contributions:** Concept: E.A., A.G.E.; Design: E.A.; Supervision: E.A., M.R.O., A.G.E.; Data collection and/or processing: E.A., A.G.E.; Analysis and/or interpretation: E.A., A.G.E., M.R.O., İ.İ.; Literature review: E.A., A.G.E.; Writing: E.A.; Critical review: M.R.O., İ.İ., B.E.

**Conflict of Interest:** None declared.

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## ORİJİNAL ÇALIŞMA - ÖZ

### Akut batın tanısı ve tedavisinde 'bekle ve BT'yi yönteminin sorun çözmedeki rolü

**AMAÇ:** Bu çalışma, acil servise akut travmatik olmayan karın ağrısı şikayetiyle başvuran hastalarda, ilk başvurudan sonraki 10 gün içinde gerçekleştirilen takip abdomenopelvik bilgisayarlı tomografi (BT) taramalarının tanısallık değerini ve sorun çözme potansiyelini değerlendirmeyi amaçlamaktadır.

**GEREÇ VE YÖNTEM:** 1 Ocak 2013 ile 30 Mayıs 2023 tarihleri arasında akut karın şikayetleri ile acil servise başvuran ve akut dönemde abdomenopelvik BT çekilen hastalar retrospektif olarak analiz edildi. Bu kohort içerisinde, aynı yatış süresi içinde tekrar abdomenopelvik BT çekilen 149 hasta belirlendi ve bulgulara göre beş gruba ayrıldı: Grup A (ilk tanıda değişiklik yok), Grup B (başlangıçta şüphelenilen tanının doğrulanması), Grup C (hastalığın progresyonu), Grup D (hastalığın regresyonu) ve Grup E (tekrarlayan BT'de yeni tanı).

**BULGULAR:** Kohortun ortalama yaşı  $51.5 \pm 18$  yıl (19–92) idi. İlk ve tekrarlayan BT çekimleri arasındaki ortalama süre  $40.9 \pm 59.05$  saat (0.5–238) olarak belirlendi. Gruplara göre hasta sayısı şu şekildeydi: Grup A (n=21), Grup B (n=60), Grup C (n=32), Grup D (n=25) ve Grup E (n=11). En sık karşılaşılan bulgu parsiyel barsak obstrüksiyonu idi (%27, 41/149); Grup D'nin %72'sinde (18/25) takip BT'de regresyon izlendi. "Bekle ve BT'yi tekrarla" yaklaşımı, parsiyel barsak obstrüksiyonunda klinik yönetim kararlarını anlamlı şekilde yönlendirdi ( $p < 0.01$ ).

**SONUÇ:** Bu çalışma, travmatik olmayan akut karın şikayeti olan hastalarda tanısallık doğruluğun artırılması ve klinik yönetimin yönlendirilmesinde "bekle ve BT'yi tekrarla" stratejisinin önemini vurgulamaktadır. Takip BT'leri özellikle parsiyel barsak obstrüksiyonu gibi durumların belirlenmesinde etkili bulunmuştur.

**Anahtar sözcükler:** Acil tıp; akut batın; barsak tıkanıklığı; bilgisayarlı tomografi; karın ağrısı.

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