

# Diagnostic Imaging Pathways - Abdominal Plain X-Ray (Indications)

## Population Covered By The Guidance

This pathway provides guidance on the indications for a plain abdominal radiograph in adult patients.

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## Quick User Guide

Move the mouse cursor over the **PINK** text boxes inside the flow chart to bring up a pop up box with salient points.

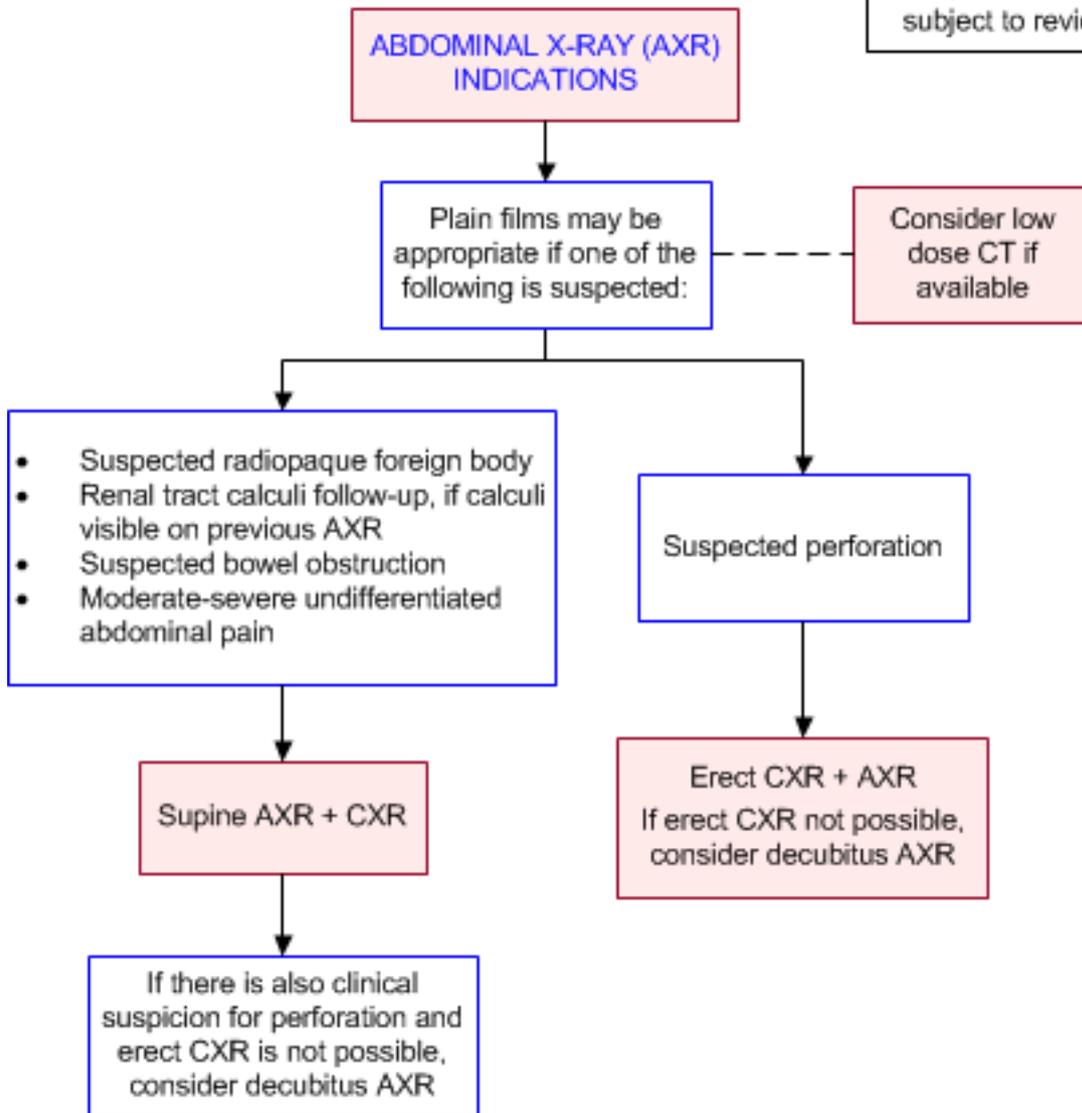
Clicking on the **PINK** text box will bring up the full text.

The relative radiation level (RRL) of each imaging investigation is displayed in the pop up box.

SYMBOL	RRL	EFFECTIVE DOSE RANGE
	None	0
	Minimal	< 1 millisieverts
	Low	1-5 mSv
	Medium	5-10 mSv
	High	>10 mSv

## Pathway Diagram

Date reviewed: September 2018  
Please note that this pathway is  
subject to review and revision



## Image Gallery

*Note: Images coming soon*

## Teaching Points

- Plain films may be appropriate for evaluation of:
  - A suspected radiopaque foreign body
  - Renal tract calculi for follow-up, if calculi have been visible on previous radiographs
  - Suspected bowel obstruction
  - Suspected perforation
  - Moderate-severe undifferentiated abdominal pain
- If logistics allow, low-dose non-enhanced CT should be performed for moderate-severe undifferentiated abdominal pain as considerably more diagnostic information can be obtained with

very little increase in dose

## Indications for Plain Abdominal Radiograph (AXR)

- The current utility of AXR is debated [1](#)
- Recommendations for radiography: [2](#)
  - Avoid radiography for conditions unlikely to be associated with radiographic signs
  - Avoid radiography in women of reproductive age group, unless a strong indication exists, and only after pregnancy has been excluded
  - Avoid radiography where it will not lead to a change in management
  - If radiography is indicated, request only a supine abdomen or a supine abdomen and erect chest radiograph (or decubitus AXR if this is not possible). A complementary view, such as erect an AXR, is to be requested only after reviewing the initial film
- Several studies have demonstrated the overuse of AXRs [3-5](#) and that the use of guidelines can significantly reduce the number of AXRs performed without missing diagnoses [6,7](#)
- AXRs are low-yield [1](#)
  - A prospective study by Thomas et al showed that about 77% films were normal, increasing to 84% if unrelated or unsuspected findings were considered [8](#)
  - Even 25 years later, Kellow et al (2008), in their retrospective study of 874 patients presenting to the Emergency Department, showed that 81% had normal or non-specific abdominal radiograph results [9](#)
- AXRs infrequently change management
  - A cohort study of 1021 patients found that AXR resulted in a change to a correct diagnosis in only 4% of patients, and increased diagnostic confidence in only a third of unchanged diagnoses [10](#)
  - In their review of 277 cases, Lee showed that plain abdominal radiographs were not helpful in 57% and were misleading in another 1% [11](#)
- Plain abdominal radiographs have little or no role in diagnosis or further investigation of gastrointestinal haemorrhage, peptic ulcer, appendicitis, urinary tract infection or non-specific abdominal pain [1,7,8,12-15](#)
- Other circumstances:
- **Foreign bodies:** AXR is sensitive and specific for foreign bodies dependent on their nature; AXR should only performed where the foreign body has clinical relevance, such as being poisonous, sharp or otherwise symptomatic. [15](#) AXR may also be used to check the position of abdominal catheters [9](#)
- **Small bowel obstruction (SBO):** AXR has traditionally been the first imaging investigation but evidence for its value is variable [16](#)
  - Some studies report accuracy approaching 80-90%, [17,18](#) similar to CT, [19](#) while others reported AXR to be of little or no help; [20,21](#) one study found AXR to be misleading in 20-40% of patients [22](#)
  - Although AXR may have a relative high accuracy for detecting SBO, CT provides much more information about the site, cause and complications of SBO, so AXR is unlikely to be definitive. In suspected SBO patients, AXR may just prolong the evaluation period while adding radiation exposure [1,16](#)
  - Some guidelines suggest that SBO may be an indication for AXR [6,19,23-26](#), while others suggest that AXR may be of more use to monitor the evolution of obstruction [1](#)
- **Urolithiasis:** Low-dose non-contrast CT is usually more appropriate to evaluate patients with suspected ureteric colic, however in a patient with recurrent symptoms, if a stone can be seen on AXR of the kidneys, ureters and bladder (KUB) then a repeat KUB might provide information at a much lower dose. [27](#) KUB may also be useful to follow up patients after lithotripsy [28](#)



- **Moderate-severe undifferentiated abdominal pain:** AXR may be appropriate in acute non-localised abdominal pain. [29](#) As previously mentioned, studies suggest that AXR in undifferentiated abdominal pain rarely changes management [10](#) and does not change the accuracy of clinical diagnosis. [30,31](#) Two studies have shown that low-dose CT can provide better clinical information than abdominal radiographs with as little as twice the radiation dose of AXR, without contrast [30,32](#)
- **Perforation:** reported sensitivities range from 15% [10](#) to 85%; [33](#) lack of free air on plain radiography does not rule out perforation. [34](#) A number of guidelines suggest that AXR is appropriate to evaluate suspected perforation. [23,26,33,35](#) Alternatively, CT is more sensitive and also gives information about the location and cause which are relevant for planning a surgical approach so in the review by Artigas Martin et al, AXR was not recommended to evaluate suspected perforation [1](#)
- **Trauma:** The use of AXR in trauma has been mostly replaced by the Focussed Assessment with Sonography for Trauma (FAST) scan, although plain radiography may still be used when this is not available [36](#)
- **Constipation:** There is a paucity of evidence addressing the role of AXR in adults with constipation. [37](#) A small cross-sectional study failed to show a strong correlation between radiographic and clinical constipation scores [38](#)

## Erect Chest Radiograph (CXR)

- A retrospective study of 250 surgically confirmed cases of hollow organ perforation found the sensitivity of erect CXR to be 85.1% compared to 80.4% for supine AXR and 98.0% for left decubitus AXR for the detection of pneumoperitoneum, though neither difference reached statistical significance [33](#)
- Lateral decubitus AXR should be considered to evaluate for perforation if erect CXR is not possible
- Reported sensitivities of AXR for perforation range from 15% [10](#) to 85%; [33](#) lack of free air on plain radiography does not rule out perforation. [34](#) A number of guidelines suggest that AXR is appropriate to evaluate suspected perforation. [23,26,33,35](#) Alternatively, CT is more sensitive and also gives information about the location and cause which are relevant for planning a surgical approach so in the review by Artigas Martin et al, AXR was not recommended to evaluate suspected perforation [1](#)

## Low-Dose Computed Tomography (LDCT)

- Several studies have validated the feasibility of non-enhanced LDCT as an alternative to AXR
- LDCT protocols have achieved doses as low as the dose of two or three abdominal radiograph series [30,32,39](#) and more recently Alshamari et al achieved an effective LDCT dose of 1.2mSv, which was comparable to 1.0mSv for AXR. [40](#) One study found that patients who underwent AXR had more subsequent AXRs which resulted in similar total radiation doses for both strategies, even when initial LDCT dose was higher [30](#)
- Compared to AXR, LDCT gave more correct diagnoses [30,32](#) and demonstrated superior sensitivity and positive predictive value [39,40](#)
- LDCT with dose less than 2.5mSv was found to have comparable accuracy to standard-dose CT, though obese patients may still require larger doses to achieve adequate diagnostic images [41](#)
- Although evidence suggests that LDCT provides higher diagnostic yield at comparable doses to AXR, logistical factors such as availability of CT scanners and reporting expertise may prevent AXR from being replaced by LDCT
- Where logistics allow, non-enhanced LDCT is recommended in place of AXR for the evaluation of

moderate-severe undifferentiated abdominal pain. AXR has been found to have low value in this setting [10,30,31](#)

## References

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