ACUTE COMPLICATIONS OF PEPTIC ULCER

1. **BLEEDING GASTRODUODENAL ULCER**
2. **PERFORATED GASTRODUODENAL ULCER**

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BLEEDING GASTRODUODENAL ULCER

BLEEDING GASTRODUODENAL ULCERS ARE OUTPOURING OF BLOOD IN THE GASTROINTESTINAL TRACT CAVITY AS A RESULT OF STRENGTHENING AND DISTRIBUTION OF NECROSIS PROCESS IN THE ULCER AREA TO VESSELS WITH THE SUBSEQUENT MELTING OF THEIR WALLS.

BLEEDING GASTRODUODENAL ULCER

COMPLICATION OF PEPTIC OR DUODENAL ULCER BY BLEEDING IS CRITICAL SITUATION WHICH THREATENS TO LIFE OF PATIENT AND REQUIRES FROM THE SURGEON OF IMMEDIATE AND DECISIVE ACTIONS FOR CLARIFICATION OF REASONS OF BLEEDING AND CHOICE OF TACTIC OF TREATMENT. THE ULCEROUS BLEEDING HAS 60 % OF THE ACUTE BLEEDING FROM THE UPPER PARTS OF GASTROINTESTINAL TRACT.

ETIOLOGY AND PATHOGENESIS

-THE ORIGIN OF THE GASTROINTESTINAL BLEEDING AT PATIENTS WITH A GASTRIC OR DUODENAL ULCER ALMOST IS ALWAYS RELATED TO EXACERBATION OF ULCEROUS PROCESS. THE REASON OF BLEEDING IS A EROSIVE VESSEL, THAT IS ON THE BOTTOM OF ULCER. THE EXPRESSED INFLAMMATORY AND SCLEROTIC PROCESSES ROUND THE DAMAGED VESSEL EMBARRASSED ITS CONTRACTION, THAT DIMINISHES CHANCES ON THE SPONTANEOUS STOP OF BLEEDING

ETIOLOGY AND PATHOGENESIS

GASTRIC ULCERS, COMPARE WITH THE ULCERS OF DUODENUM, COMPLICATED BY BLEEDING MORE FREQUENT. BLEEDING AT GASTRIC ULCERS ARE MORE EXPRESSED, PROFUSE, WITH HEAVY PASSING.

AT THE DUODENAL ULCER BLEEDING MORE FREQUENT COMPLICATE THE ULCERS OF BACK WALL, WHICH PENETRATES IN THE HEAD OF PANCREAS.

ETIOLOGY AND PATHOGENESIS

AT THE MEN ULCER IS COMPLICATED BY BLEEDING TWICE MORE FREQUENT, THAN AT WOMEN. IT COSTS TO MARK THAT 80 % PATIENTS WHICH CARRIED BLEEDING FROM AN ULCER AND TREATED ONESELF BY CONSERVATIVE PREPARATIONS, ARE UNDER THE PERMANENT THREAT OF THE RECURRENT BLEEDING.

PATHOMORPHOLOGY

STRENGTHENING OF NECROSIS PROCESS ARE LEADING FACTORS IN THE ORIGIN OF THE ULCEROUS BLEEDING IN THE AREA OF ULCEROUS CRATER WITH DISTRIBUTION OF THIS PROCESS TO A VESSEL AND SUBSEQUENT MELTING OF VASCULAR WALL; ACTIVATION OF FIBRINOLYSIS IN TISSUES OF STOMACH AND DUODENUM; ISCHEMIA OF TISSUES OF WALL OF STOMACH

CLASSIFICATION

BLEEDING GASTRODUODENAL ULCERS AFTER THE DEGREE OF WEIGHT OF LOSS OF BLOOD (BY O.O. SHALIMOV AND V.F.SAENKO, 1987) ARE DIVIDED:

I DEGREE IS EASY — OBSERVED AT THE LOSS TO 20 % VOLUME OF CIRCULATORY BLOOD (AT A PATIENT WITH WEIGHT OF BODY 70 KG IT IS UP TO 1000 ML);

II DEGREE — MIDDLE WEIGHT IS LOSS FROM 20 TO 30 % VOLUME OF CIRCULATORY BLOOD (1000–1500 ML);

THE III DEGREE IS HEAVY — IS OBSERVED AT LOSS OF BLOOD MORE THAN 30 % VOLUME OF CIRCULATORY BLOOD (1500–2500 ML).

CLINICAL MANAGEMENT

AT PATIENTS WITH AN PEPTIC ULCER DISEASE, BLEEDING POPS UP, MAINLY AT NIGHT. VOMITING CAN BE THE FIRST SIGN OF IT, MOSTLY, AT GASTRIC LOCALIZATION OF ULCERS. VOMITING MASSES, AS A RULE, LOOKS LIKE “COFFEE-GROUNDS”. SOMETIMES THEY ARE AS A FRESH RED BLOOD OR ITS GRUME.

CLINICAL MANAGEMENT

THE BLACK TAR-LIKE EMPTYING ARE THE PERMANENT SYMPTOM OF THE ULCEROUS BLEEDING, WITH AN UNPLEASANT SMELL (“MELENA”), THAT CAN TAKE PLACE TO A FEW TIMES PER DAYS.

BLOODY VOMITING AND EMPTYING AS “MELENA” IS ACCOMPANIED BY WORSENING OF THE GENERAL CONDITION OF PATIENT. A ACUTE WEAKNESS, DIZZINESS, NOISE IN A HEAD AND DARKENING IN EYES, SOMETIMES — LOSS OF CONSCIOUSNESS. A COLLAPSE WITH THE SIGNS OF HEMORRHAGIC SHOCK CAN ALSO DEVELOP. EXACTLY WITH A SUCH CLINICAL PICTURE THE SUCH PATIENTS GET TO THE HOSPITAL.

IT IS NEEDED TO REMEMBER, THAT FOR DIAGNOSTICS ANAMNESIS IS VERY IMPORTANT. FIND OUT OFTEN, THAT AT A PATIENT AN PEPTIC ULCER WAS ALREADY DIAGNOSED ONCE. IT APPEARS SOMETIMES, THAT BLEEDING IS REPEATED OR SURGERY CONCERNING A PERFORATED ULCER TOOK PLACE IN THE PAST.

AT SOME PATIENTS A GASTRIC OR DUODENUM ULCER IS WAS NOT DIAGNOSED BEFORE, THE HOWEVER ATTENTIVELY COLLECTED ANAMNESIS EXPOSED, THAT AT A PATIENT HAD A STOMACH-ACHE. THUS IT COMMUNICATION WITH ACCEPTANCE OF FOOD AND SEASONALITY IS TYPICAL (MORE FREQUENT APPEARS IN SPRING AND IN AUTUMN)

PATIENTS TELL, THAT PAIN IN OVERHEAD PART OF ABDOMEN WHICH DISTURBED A FEW DAYS PRIOR TO BLEEDING SUDDENLY DISAPPEARED AFTER FIRST ITS DISPLAYS (THE BERGMANN'S SYMPTOM).

AT PATIENTS WITH THE ULCEROUS BLEEDING THERE ARE THE TYPICAL CHANGES OF HEMODYNAMIC INDEXES: A PULSE IS FREQUENT, WEAK FILLING AND TENSION, ARTERIAL PRESSURE IS MOSTLY REDUCED. THESE INDEXES NEED TO BE OBSERVED IN A DYNAMICS, AS THEY CAN CHANGE DURING THE SHORT INTERVAL OF TIME.

THERE IS THE PALLOR OF SKIN AND VISIBLE MUCOUS TUNICS AT A EXAMINATION. A STOMACH SOMETIMES IS MODERATELY EXAGGERATED, BUT MORE FREQUENT IS PULLED IN, SOFT AT PALPATION. IN OVERHEAD PART IT IS POSSIBLE TO NOTICE HYPERPIGMENTAL SPOTS — TRACKS FROM THE PROTRACTED APPLICATION OF HOT-WATER BOTTLE.

PAINFUL AT DEEP PALPATION IN THE AREA OF RIGHT HYPOCHONDRIUM (DUODENAL ULCER) OR IN A EPIGASTRIC AREA (GASTRIC ULCER) IT IS POSSIBLE TO OBSERVE AT PENETRATED ULCERS. IMPORTANT SYMPTOM OF MENDEL ALSO — PAINFUL AT PERCUSSION IN THE PROJECTION OF PILORODUODENAL AREA.

AT THE EXAMINATION OF PATIENTS WITH THE GASTROINTESTINAL BLEEDING FINGER EXAMINATION OF RECTUM IS OBLIGATORY. IT NEEDS TO BE PERFORMED AT THE FIRST EXAMINATION, BECAUSE INFORMATION ABOUT THE PRESENCE OF BLACK EXCREMENT ("MELENA") MORE FREQUENT GET ACCORDING TO A PATIENT ANAMNESIS, THAT CAN RESULT IN ERRONEOUS CONCLUSIONS.

FINGER EXAMINATION OF RECTUM ALLOWS TO EXPOSE TRACKS OF BLACK EXCREMENT OR BLOOD. IN ADDITION, IT IS SOMETIMES POSSIBLE TO EXPOSE THE TUMOUR OF RECTUM OR HAEMORRHOIDAL KNOTS WHICH ALSO ARE THE SOURCE OF BLEEDING.

THE DECIDING VALUE IN ESTABLISHMENT OF DIAGNOSIS HAS THE ENDOSCOPIC EXAMINATION. FIBER-GASTRODUODENOSCOPY ENABLES NOT ONLY TO DENY OR CONFIRM THE PRESENCE OF BLEEDING BUT ALSO, THAT IT IS ESPECIALLY IMPORTANT, TO SET ITS REASON AND SOURCE. OFTEN EMBARRASSED THE EXAMINATION OF STOMACH AND DUODENUM PRESENT IN IT BLOOD AND CONTENT. IN SUCH CASES IT IS NECESSARY TO REMOVE BLOOD OR CONTENT, BY GASTRIC LAVAGE, AND TO REPEAT ENDOSCOPIC EXAMINATION.

DURING THE EXAMINATION OFTEN EXPOSED THE BLEEDING WITH FRESH BLOOD FROM THE BOTTOM OF ULCER OR ULCEROUS DEFECT WITH ONE OR A FEW EROSIVE AND THROMBOSED VESSELS (STOPPED BLEEDING). THE BOTTOM OF ULCER CAN BE COVERED BY THE PACKAGE OF BLOOD.

IMPORTANT INFORMATION ABOUT SUCH PATHOLOGY IS GIVEN BY HAEMATOLOGICAL INDEXES ALSO. DIMINISHMENT OF NUMBER OF RED CORPUSCLES AND HAEMOGLOBIN OF BLOOD, DECLINE OF HAEMATOCRITIS IS OBSERVED IN SUCH PATIENTS.

HOWEVER ALWAYS NEEDED TO REMEMBER, THAT AT FIRST TIME AFTER BLEEDING HAEMATOLOGICAL INDEXES CAN CHANGE INSIGNIFICANTLY. CONDUCTING OF GLOBAL ANALYSIS OF BLOOD IN A DYNAMICS IN EVERY A FEW HOURS IS MORE INFORMING.

VARIANTS OF CLINICAL PASSING AND COMPLICATION

IT IS NECESSARY ALWAYS TO REMEMBER THAT COMPLICATION OF PEPTIC ULCER BY BLEEDING HAPPENS CONSIDERABLY MORE FREQUENT, THAN IS DIAGNOSED. USUALLY, TO 50–55 % MODERATE BLEEDING (MICROBLEEDING) HAVE THE HIDDEN PASSING. THE MASSIVE BLEEDING MEET CONSIDERABLY RARER, HOWEVER ALMOST ALWAYS RUN ACROSS WITH THE BRIGHTLY EXPRESSED CLINICAL SIGNS WHICH OFTEN CARRIES DRAMATIC CHARACTER. IN FACT PROFUSE BLEEDING WITH THE LOSS 50–60 % TO THE VOLUME OF CIRCULATORY BLOOD COULD STOP THE HEART AND CAUSE THE DEATH OF PATIENT.

THE CLINICAL SIGNS AND PASSING OF DISEASE DEPEND ON THE DEGREE OF LOST OF BLOOD (0.0. SHALIMOV AND V.F.SAENKO, 1987).

- FOR LOST OF BLOOD **I DEGREE** TYPICAL THERE IS A FREQUENT PULSE TO 90–100, DECLINE OF ARTERIAL PRESSURE OF TO 90/60 MM HG. THE EXCITABILITY OF PATIENT CHANGES BY LETHARGY, HOWEVER CLEAR CONSCIOUSNESS IS, BREATHING SOME FREQUENT. AFTER THE STOP OF BLEEDING AND IN ABSENT OF HEMORRHAGE COMPENSATION THE EXPRESSED DISTURBANCES OF CIRCULATION OF BLOOD DOES NOT OBSERVE.

AT PATIENTS WITH THE **II DEGREE** OF HEMORRHAGE THE GENERAL CONDITION NEEDS TO BE ESTIMATED AS AVERAGE. EXPRESSED PALLOR OF SKIN, STICKY SWEAT, LETHARGY. PULSE — 120–130 PER MIN., WEAK FILLING AND TENSION, ARTERIAL PRESSURE — 90–80/50 MM HG. AT FIRST HOURS THE SPASM OF VESSELS (CENTRALIZATION OF CIRCULATION OF BLOOD) COMES AFTER BLEEDING, THAT PREDETERMINES NORMAL OR INCREASED, ARTERIAL PRESSURE. HOWEVER, AS A RESULT OF THE PROTRACTED BLEEDING COMPENSATE MECHANISMS OF ARTERIAL PRESSURE ARE EXHAUSTED AND CAN ACUTELY GO DOWN AT ANY POINT

THE **III DEGREE** OF HEMORRHAGE CHARACTERIZES HEAVY CLINICAL PASSING. THERE IS A PULSE IN SUCH PATIENTS — 130–140 PER MIN., AND ARTERIAL PRESSURE — FROM 60 TO 0 MM HG. CONSCIOUSNESS IS ALMOST ALWAYS DARKENED, ACUTELY EXPRESSED ADYNAMY. CENTRAL VEIN PRESSURE IS LOW. OLIGURIA IS OBSERVED, THAT CAN CHANGE BY ANURIA. WITHOUT ACTIVE AND DIRECTED CORRECTION OF HEMORRHAGE A PATIENT CAN DIE.

IT IS NEEDED TO REMEMBER, THAT THE ULCEROUS BLEEDING CAN ACCOMPANYING WITH THE PERFORATION OF ULCER. DURING PERFORATION ULCERS ARE OFTEN ACCOMPANIED BY BLEEDING. CORRECT DIAGNOSTICS OF THESE TWO COMPLICATIONS HAS THE IMPORTANT VALUE IN TACTICAL APPROACH AND IN THE CHOICE OF METHOD OF SURGICAL TREATMENT. IN FACT SIMPLE SUTURING OF PERFORATED AND BLEEDING ULCER CAN COMPLICATED IN POSTOPERATIVE PERIOD BY THE PROFUSE BLEEDING AND CAUSE THE NECESSITY OF THE REPEATED OPERATION.

DIAGNOSIS PROGRAM

1. ANAMNESIS AND PHYSICAL EXAMINATION.
2. FINGER EXAMINATION OF RECTUM.
3. GASTRODUODENOSCOPY.
4. GLOBAL ANALYSIS OF BLOOD.
5. COAGULOGRAM.
6. 7. BIOCHEMICAL BLOOD TEST.
7. X-RAY EXAMINATION OF GASTROINTESTINAL TRACT.
8. ELECTROCARDIOGRAPHY.

TACTIC AND CHOICE OF TREATMENT METHOD

THE CONSERVATIVE THERAPY INDICATED TO PATIENTS WITH THE STOPPED BLEEDING OF I DEGREE AND BLEEDING OF THE II–III DEGREES AT PATIENTS WHICH HAVE HEAVY ACCOMPANYING PATHOLOGY, BECAUSE OF OPERATIVE RISK.

CONSERVATIVE THERAPY MUST INCLUDE:

- PRESCRIPTION OF HEMOSTATIC PREPARATIONS (INTRAVENOUSLY THE AMINOCAPRONIC ACID 5 % — 200–400 ML, CHLOROUS CALCIUM 10 % — 10,0 ML, VICASOL 1 % — 3,0 ML);

- ADDITION TO THE VOLUME OF CIRCULATORY BLOOD (GELATIN, POLIGLUKINE, SALT BLOOD SUBSTITUTES);

- PREPARATIONS OF BLOOD (FIBRINOGEN — 2–3 Г, CRYOPRECIPITATE);

- BLOOD SUBSTITUTES THERAPY (RED CORPUSCLES MASS, WASHED RED CORPUSCLES, PLASMA OF BLOOD);

- ANTIULCEROUS PREPARATIONS — BLOCKER OF H2- RECEPTOR (RANITIDINE, ROXATIDINE, NASATIDINE— FOR 150 MG 1–2 TIMES PER DAYS);

- ANTACID AND ADSORBENTS (ALMAGEL, PHOSPHALUGEL, MAALOX— FOR 1–2 DESSERT-SPOONS THROUGH 1 HOUR AFTER FOOD INTAKE).

- THE ENDOSCOPIC METHODS OF STOP OF BLEEDING ARE USED ALSO. AMONG THEM MOST EFFECTIVE IS A LASER AND ELECTRO-COAGULATION.

ABSOLUTE INDICATIONS TO SURGICAL TREATMENT ARE: 1) LASTING BLEEDING I DEGREE; 2) RECURRENT BLEEDING AFTER HEMORRHAGE I DEGREE; 3) BLEEDING OF THE II–III DEGREES; 4) STOPPED BLEEDING WITH HEMORRHAGE OF THE II–III DEGREES AT THE ENDOSCOPICALLY EXPOSED ULCEROUS DEFECT WITH A PRESENCE ON THE ULCER BOTTOM THROMBOSED VESSELS OR EROSIVE VESSELS COVERED BY THE PACKAGE OF BLOOD.

- THE CHOICE OF METHOD OF SURGICAL TREATMENT ALWAYS NEEDS TO BE DECIDED INDIVIDUALLY

- PALLIATIVE OPERATIONS (CUTTING OF ULCER, FORMING OF ROUNDABOUT ANASTOMOSIS) CAN BE JUSTIFIED ONLY TAKING INTO ACCOUNT THE GENERAL CONDITION OF PATIENT AND ON A NECESSITY AS POSSIBLE QUICK AND LEAST TRAUMATICALLY TO MAKE OFF OPERATION.

AT THE BLEEDING ULCERS OF DUODENUM IT IS BETTER TO APPLY EXCISION OF ULCER OR IT EXTERITIRIZATION AFTER METHODS.

OPERATION COMPLEMENTED BY ONE OF TYPES OF VAGOTOMY, IT IS BETTER BY A SELECTIVE PROXIMAL WITH PILIROPLASTIC.

THE RESECTION OF STOMACH ON THE SECOND OR FIRST METHOD OF BILROTH CAN BE REALIZED ONLY IN THE STABLE GENERAL CONDITION OF PATIENT.

PERFORATED GASTRODUODENAL ULCERS

PERFORATED GASTRODUODENAL ULCERS

THE TYPICAL PERFORATION OF GASTRIC OR DUODENUM ULCER IS STRENGTHENING OF NECROSIS PROCESS IN THE AREA OF ULCEROUS CRATER WITH SUBSEQUENT DISTURBANCE OF INTEGRITY OF WALL, THAT RESULT TO THE PERMANENT EFFLUENCE OF GASTRODUODENAL CONTENT AND AIR IN A FREE ABDOMINAL CAVITY.

ETIOLOGY AND PATHOGENESIS

ULCERS, WHICH LIE ON THE FRONT WALL OF STOMACH AND DUODENUM MORE FREQUENT GIVE THE PERFORATION WITH GENERAL PERITONITIS, WHILE ULCERS ON A BACK WALL — PERFORATION WITH ADHESIVE INFLAMMATION.

THE REASONS OF ULCERS PERFORATION ARE: EXACERBATION OF PEPTIC ULCER, HARMFUL HABITS, STRESSES, PROFESSIONAL, ATHLETIC OVEREXERTION, FAULTS IN THE FEED AND ABUSES BY STRONG WATERS.

PATHOMORPHOLOGY

IN PATHOGENY OF ACUTE PERFORATION IMPORTANT: PROGRESSIVE NECROSIS PROCESSES IN THE AREA OF ULCEROUS CRATER WITH ACTIVATING OF VIRULENT INFECTION; HYPERERGIC TYPE OF LOCAL VACULO-STROMAL REACTION WITH THE THROMBOSIS OF VEINS OF STOMACH AND DUODENUM; LOCAL MANIFESTATION OF AUTOIMMUNE CONFLICT WITH ACCUMULATION OF SOUR MUCOPOLYSACCHARIDES ON PERIPHERY OF ULCER AND HIGH COEFFICIENT OF PLASMATIZATION OF MUCOUS TUNIC (K.I. MISHKIN, A.A. FRANKFURT, 1971).

CLASSIFICATION

PERFORATED GASTRODUODENAL ULCERS ARE DIVIDED:

1. AFTER ETIOLOGY:

— ULCEROUS;

— UNULCEROUS.

2. AFTER LOCALIZATION:

— GASTRIC (SMALL CURVATURE, CARDIAL, ANTRAL, PREPYLORIC, PYLORIC) ULCER, FRONT AND BACK WALLS;

— ULCERS OF DUODENUM (FRONT AND BACK WALLS).

3. AFTER PASSING:

— PERFORATED IN AN ABDOMINAL CAVITY;

— COVERED PERFORATIONS;

— ATYPICAL PERFORATIONS.

CLINICAL MANAGEMENT

THE CLINICAL PICTURE OF PERFORATION IS VERY TYPICAL AND DEPENDS ON DISTRIBUTION OF INFLAMMATORY PROCESS AND INFECTION OF ABDOMINAL CAVITY. IN CLINICAL PASSING OF THE PERFORATIONS DISTINGUISH THREE PHASES: SHOCK, “IMAGINARY PROSPERITY” AND PERITONITIS (MONDOR, 1939).

CLINICAL MANAGEMENT

FOR THE PHASE OF SHOCK (TO 6 HOURS LAST) TYPICAL VERY ACUTE PAIN IN EPIGASTRIC REGION (DELAFUA COMPARES IT TO PAIN FROM THE STAB WITH A DAGGER) WITH AN IRRADIATION IN A RIGHT SHOULDER AND COLLAR-BONE, A FACE IS PALE, WITH EXPRESSION OF STRONG FEAR, LINES BECOME (FACIES ABDOMINALIS) ACUTE, A DEATH-DAMP IRRIGATES SKIN COVERS. A PULSE IS AT FIRST SLOW (VAGUS PULSE), LATER BECOMES FREQUENT AND LESS FILLING. SOMETIME OBSERVED THE REFLEX VOMITING AND DELAY OF GASES. ARTERIAL PRESSURE IS REDUCED.

CLINICAL MANAGEMENT

ON EXAMINATION STOMACH IS PULLS IN, DOES NOT TAKE PART IN THE ACT OF BREATHING. AT PALPATION IS “WOODEN BELLY STOMACH”, ESPECIALLY IN AN UPPER PART, WHERE, USUALLY, THERE IS MOST PAIN. POSITIVE BLUMBERG'S SIGN. AT PERCUSSION IS DISAPPEARANCE OF HEPATIC DULLNESS (THE SPIZHARNYY SYMPTOM). AT RECTAL EXAMINATION EXPOSE PAINFUL IN THE AREA OF RECTOUTERINE OR RECTOVESICAL POUCH (THE KULENKAMPFF'S SYMPTOM).

CLINICAL MANAGEMENT

THE PHASE OF SHOCK CHANGES BY THE PHASE OF “IMAGINARY PROSPERITY”, WHEN THE REFLEX SIGNS GO DOWN: THE GENERAL CONDITION OF PATIENT GETS BETTER, A PULSE BECOMES NORMAL, ARTERIAL PRESSURE RISES, A STOMACH-ACHE DIMINISHES PARTLY. HOWEVER OBSERVED TENSION OF MUSCLES OF FRONT ABDOMINAL WALL, POSITIVE BLUMBERG'S SIGN.

CLINICAL MANAGEMENT

THE PHASE OF “IMAGINARY PROSPERITY” IN 6–12 HOURS FROM THE MOMENT OF PERFORATION CHANGES BY THE PHASE OF PERITONITIS: A PULSE IS FREQUENT, A STOMACH IS SWOLLEN THROUGH GROWING FLATULENCE, INTESTINAL NOISES ARE NOT LISTENED, A FACE ACQUIRES THE SPECIFIC KIND — FACIES HIPPOCRATICA —THE EYES FALL BACK, LIPS TURN BLUE, A NOSE BECOMES SHARP, A TONGUE BECOMES DRY AND FURRED, BREATHING SUPERFICIAL AND FREQUENT, A TEMPERATURE RISES.

DIAGNOSIS PROGRAM

1. ANAMNESIS AND PHYSICAL EXAMINATION.

2. GLOBAL ANALYSIS OF BLOOD AND URINE, BIOCHEMICAL BLOOD TEST,

COAGULOGRAM.

3. X-RAY EXAMINATION OF ABDOMINAL CAVITY ORGANS FOR PRESENCE OF FREE GAS (PNEUMOPERITONEUM).

4. PNEUMOGASTROGRAPHY, CONTRASTING PNEUMOGASTROGRAPHY.

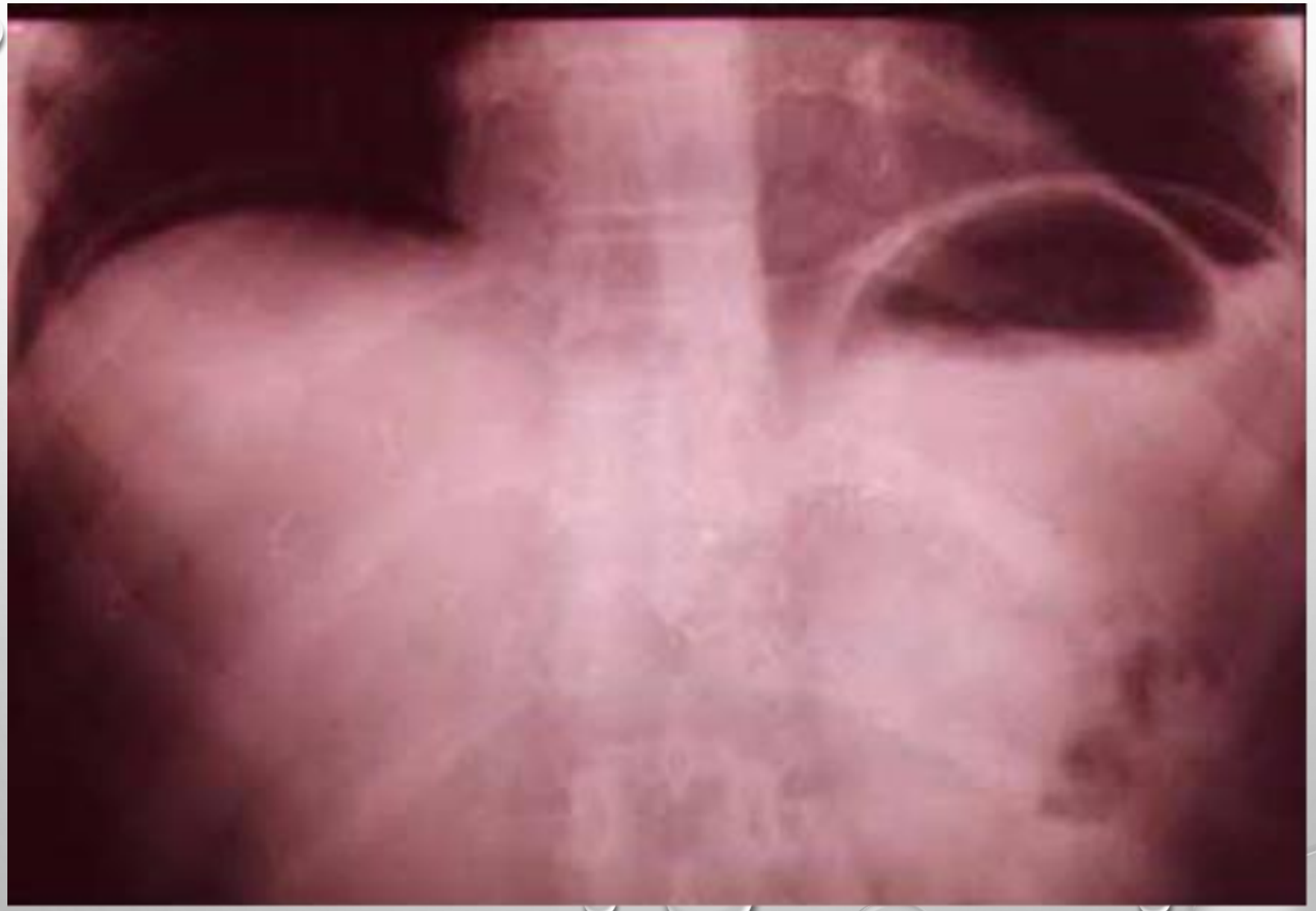
5. FIBER-GASTRODUODENOSCOPY.

6. SONOGRAPHY OF ABDOMINAL CAVITY ORGANS.

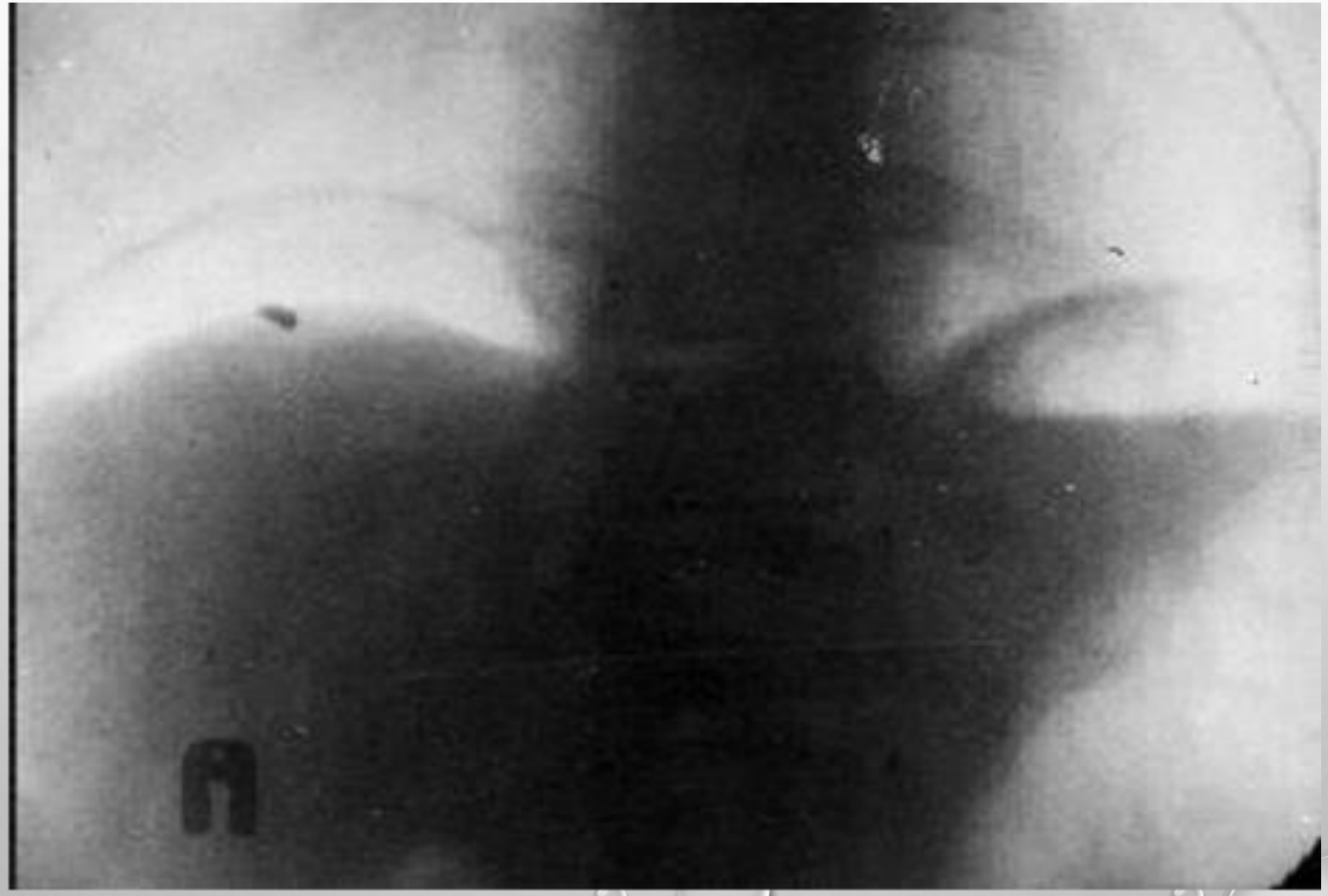
7. LAPAROCENTESIS WITH THE NEYMARK DIAGNOSTIC TEST (TO THE 2–3 ML OF ABDOMINAL CAVITY EXUDATE ADDS 4–5 DROPS OF THE 10 % SOLUTION OF IODINE. IF THE ADMIXTURES OF GASTRIC CONTENT APPEAR IN EXUDATE, THEN UNDER ACTION OF IODINE GASTRIC CONTENT GETS A DIRTILY-DARK BLUE COLOR).

8. LAPAROSCOPY.

X-RAY EXAMINATION OF ABDOMINAL CAVITY ORGANS



X-RAY EXAMINATION OF ABDOMINAL CAVITY ORGANS. PRESENCE OF FREE GAS (PNEUMOPERITONEUM).



TACTIC AND CHOICE OF TREATMENT METHOD

THE DIAGNOSED PERFORATED GASTRIC AND DUODENUM ULCER IS AN ABSOLUTE INDICATIONS TO OPERATION.

CONSERVATIVE TREATMENT (METHOD OF TEJLOR, 1946) CAN BE JUSTIFIED AT THE REFUSAL OF PATIENT FROM OPERATION OR IN DEFAULT OF CONDITIONS FOR ITS IMPLEMENTATION.

IT MUST INCLUDE:

— PERMANENT NASOGASTRAL ASPIRATION OF GASTRIC CONTENT;

— INTRODUCTION OF PREPARATIONS WHICH BRAKE A GASTRIC SECRETION (ATROPINE, H2- BLOCKERS AND OTHERS LIKE THAT);

— INTRODUCTION OF ANTIBIOTICS;

— CORRECTION OF METABOLISM;

— LAPAROCENTESIS WITH DRAINAGE AND CLOSED LAVAGE OF THE ABDOMINAL CAVITY.

IN THE DECISION OF QUESTION ABOUT THE CHOICE OF METHOD OF OPERATIVE TREATMENT OF PERFORATED GASTRODUODENAL ULCERS THE IMPORTANT VALUE HAS THE FOLLOWING FACTORS: LOCALIZATION OF ULCER, CLINICO-MORPHOLOGICAL DESCRIPTION OF ULCER (PERFORATION OF ACUTE OR CHRONIC ULCER), CONNECTED WITH THE PERFORATION SUCH COMPLICATIONS OF ULCER, AS BLEEDING, CICATRICIAL-ULCEROUS STENOSIS, PENETRATION, DEGREE OF RISK OF OPERATION AND FEATURE OF CLINICAL SITUATION.

OPERATIVE TREATMENTS AT A PERFORATED ULCER DIVIDE INTO PALLIATIVE AND RADICAL.

PALLIATIVE OPERATIONS

PALLIATIVE OPERATIONS ARE: CLOSURE OF THE PERFORATIVE HOLE OF ULCER, TAMPONADE OF THE PERFORATIVE HOLE BY A OMENTUM ON A LEG BY B.A. OPPEL - P.N.POLIKARPOV - M.A.PIDHORBUNSKYY (1896, 1927, 1948)

INDICATIONS AND TERMS FOR THEIR IMPLEMENTATION

— PERFORATION OF ACUTE DUODENAL ULCER IN YOUTH AND YOUNG AGE WITHOUT ANAMNESIS;

— PERFORATION OF ACUTE ULCER IN THE II–III PHASES OF PASSING;

— PERFORATION OF CALLOUS GASTRIC ULCER IN THE II–III PHASES OF PASSING;

— EXPRESSED AND HIGH DEGREES OF RISK OF OPERATION.

RADICAL OPERATIONS

THE RADICAL OPERATIONS AT PERFORATED ULCERS ARE: RESECTION OF STOMACH AND EXCISION OF THE PERFORATIVE HOLE OF ULCER IN COMBINATION WITH PYLOROPLASTY AND STV, SV OR SPV.

INDICATIONS AND TERMS FOR IMPLEMENTATION OF RESECTION OF STOMACH

— PERFORATION OF CALLOUS GASTRIC ULCER IN I PHASE OF CLINICAL PASSING;

— REPEATED PERFORATION OF ULCER;

— PERFORATION OF ULCER IN I PHASE OF CLINICAL PASSING IN COMBINATION WITH STENOSIS AND BLEEDING OF ULCER;

— PERFORATION OF DUODENAL ULCER IN I PHASE OF PASSING IN COMBINATION WITH A GASTRIC ULCER;

— UNEXPRESSED AND MODERATE DEGREE OF RISK OF OPERATION;

— SUFFICIENT QUALIFICATION OF SURGEON AND MATERIAL RESOURCES OF OPERATING-ANAESTHETIC BRIGADE.