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EROSION GASTRODUODENITE – AS A COMPLICATION AFTER OPERATION IN PERFORATE ULCER PATIENTS

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Abstract

The surgical treatment for perforated peptic ulcer is still a matter of discussion. The surgeons, for many years, made their options between acid-reducing procedures with some morbi-mortality and simpler procedures like closure of the perforation. But, in these cases, were faced with a high chance of ulcer relapse. The origin reasons of one of the most serious complications after operation – the erosion gastroduodenite were revealed on the basis of investigation of 143 patients during 1 – 5 years who were operated with the perforate ulcer diagnosis. The optimum ways of prophylaxis and treatment of the given complication are outlined.

Key words: an ulcer disease, a perforate ulcer, an operation treatment, vagotomiya, distant results, the erosion gastroduodenite.

Introduction. The surgical treatment for perforated peptic ulcer is still a matter of discussion. The surgeons, for many years, made their options between acid-reducing procedures with some morbi-mortality and simpler procedures like closure of the perforation

[1, 6]. But, in these cases, were faced with a high chance of ulcer relapse. Erosive gastroduodenitis, most likely, is second in severity and significance, after relapse of the ulcer, complication of surgical treatment of peptic ulcer as a whole, and perforated ulcers in particular [1, 2]. The problem of this disease was treated practically from the moment when the ulcerative disease was treated operatively [4]. Erosion of small curvature, pyloric section and upper segment of duodenum directly attributed to the problem of peptic ulcer, considering the presence of erosion by the pre-ulcer state [3, 5]. In this regard, the **purpose of our work** is to identify the timing and causes of erosive gastroduodenitis in the postoperative period in patients with perforated ulcers, as well as assess its diagnosis and treatment.

Materials and methods. In the 25th city clinical multidisciplinary hospital, 143 patients underwent perforated ulcers in the period from 2011 to 2015. All patients underwent excision of ulcer substrata with pyloric or duodenoplasty in combination with one of the types of vagotomy. Patients were examined in terms of 1 to 5 years. The following types of examination were performed: X-ray contrast study of the stomach and duodenum, electrogastrography, intragastric ballometry, esophagogastroduodenoscopy, intragastric pH-metry, examination for helicobacteriosis, clinical laboratory examination. The statistical processing of the material was carried out using the Microsoft Office Excel 2006 program. The survey was conducted both on the basis of the 25 city clinical multidisciplinary hospital and on the basis of the state institution "Institute of General and Urgent Surgery of the Academy of Medical Sciences of Ukraine".

Results and its discussion. Of 143 patients operated on for perforating pyloroduodenal ulcers in the postoperative period, erosive gastroduodenitis was detected in 12 (8.39%) patients.

The clinical picture resembled that of a relapse of a peptic ulcer. Patients complained of pain in the epigastric region of the aching nature, belching sour, heartburn. In 5 patients, the so-called "hungry pains" were observed, in 4 patients the pain syndrome with food was not associated, and 3 people periodically noted a feeling of heaviness in the epigastric region, which increased after eating. The bright interval in patients with erosive gastroduodenitis ranged from 1 year to 3 years. Later, against the background of the treatment, 6 people recovered and they refused further examination.

At X-ray examination, normal evacuation from the stomach was noted in 4 patients, in 8 patients there were various disorders of gastroduodenal patency: in 5 patients there were

diagnosed signs of violation of duodenal patency - stasis of contrast mass in the lower horizontal branch of duodenum lasted from 6 to 14 minutes, which we associate with the mobilization of the 12 duodenal ulcer in Kocher-Clermont. At the same time there were no clinical manifestations of duodenitis; In 3 patients gastric stasis was diagnosed - complete emptying of the stomach occurred, on average, in terms of 8 to 10 hours.

With endoscopic examination, there was a satisfactory function of pyloric beet pulp that did not completely close due to previous pyloroplasty. Erosive changes in the mucosa were detected in the antrum, in the pyloroplasty area and in the initial section of the duodenum. It should be noted that total gastritis was not detected in any case. Surface planar erosion was detected in 3 patients of Whites, 7 small-point erosions, and 2 erosions of mixed type. In all patients with erosive gastroduodenitis, reflux of duodenal contents in the stomach with reflux-gastritis phenomena was expressed to varying degrees. In 2 patients, in the pyloroplasty zone, ligatures that were removed endoscopically were visually determined in the center of planar erosion. On control endoscopy after 5 days in these patients, erosions healed and noted only reflux of bile and duodenal contents in the stomach of the I degree.

The study of the acid-producing function of the stomach in patients with erosive gastroduodenitis made it possible to identify 2 groups of patients. In the first group (7 patients) the disease proceeded against a background of hypersecretion, in the second group (5 patients) normal acid production indicators were noted. Considering the fact that all patients were repeatedly examined after the operation, high acid production in all patients of the first group was detected already in the early period. From the above, it can be concluded that in these patients the operation did not lead to an adequate reduction in the acid-producing function, and only 3 years later, in the background of conservative therapy, a decrease in acid production with regression of gastroduodenitis was noted in 3 patients, in 2 patients there was a sharp increase in secretory activity in the long term, and in one observation the acid production indicators remained stable. After excluding other diseases from these patients that can lead to hypersecretion, incomplete vagotomy is recognized as the cause of erosive gastroduodenitis. In 5 patients included in group 2, erosive gastritis developed at normal rates.

When studying the motor function of the stomach and duodenum in patients of the 2nd group, the decrease in the rhythm of contractions of the proximal divisions of the 12th gut was determined. The results of the complex study indicated that in all the observations there was a violation of duodenal patency of the functional nature in the compensation stage, and only in 1 case the violation of duodenal patency was in the subcompensation stage. Consequently, in 5 cases, the development of erosive gastroduodenitis occurred as a result of

impaired motor function of the duodenum. In our opinion, this pathology arises as a result of mobilization of the duodenal ulcer during the operation.

One of the most significant factors in the development of erosive gastroduodenitis is incomplete vagotomy. All patients with erosive gastroduodenitis underwent complex antiulcer therapy taking into account the pathogenetic mechanisms of this complication. This in turn allowed 50% of cases to cure patients, and in other cases, a pronounced positive effect.

In this regard, patients with erosive gastroduodenitis continue to be "dangerous for relapse" and need further follow-up care and preventive courses of antiulcer therapy. The expediency of such a tactic is due to the fact that none of the patients in this group, despite long observation periods (from 1 to 5 years), did not relapse.

Conclusions:

One of the most significant factors in the development of erosive gastroduodenitis is incomplete vagotomy. Another equally important factor for the development of the disease is a violation of the duodenal patency of a functional nature, which is most likely due to gross manipulations in the mobilization of the duodenum of Kocher-Clermont. All patients with erosive gastroduodenitis have, in varying degrees, reflux of bile and duodenal contents into the stomach, which is probably also one of the triggers in the formation of erosion. Patients with erosive gastroduodenitis need long-term follow-up care and preventive courses of antiulcer therapy, which allows to avoid recurrence of peptic ulcer.

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