Need for pyloroplasty and vagotomy in case of perforated duodenal ulcer

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Aim. Estimation of the incidence of stenosis, need for pyloroplasty and validity of vagotomy for perforated duodenal ulcer (PDU).

Materials and methods. Twenty-year nature of surgical treatment of patients with PDC in the hospital surgery clinic is analyzed.

Results. Over 20 years, 726 patients were operated on: 151 women (20.8%), 575 men (79.2%), mean age 39.1±6.3 years. Surgeries were performed both from laparotomic access and video laparoscopically. It is found that PDU is combined with stenosis in 8.5% and with bleeding in 1.6%, which requires Jadd excision of an ulcer on the anterior wall or gastroduodenotomy for flashing a bleeding ulcer on the posterior wall (0.7%) with subsequent Heineke — Mikulicz pyloroplasty and vagotomy. Both stem vagotomy and selective proximal were used by the method of skeletonization of lesser curvature or chemoneurolysis. Suturing with selective proximal vagotomy was performed in 567 patients, isolated suturing — in 77. B-II distal gastric resection was required in 2.1%. Repeated admission of patients with complications of a duodenal ulcer is observed after isolated suturing of PDU without surgical intervention in the mechanisms of ulcer formation.

Conclusion. During surgical treatment of PDU are found in 79.2% of men, in 20.8% of women. There is an emerging stenosis in 8.5% of those who have PDU, which requires a gastric drainage operation. The subjects of choice may be Heineke-Mikulicz pyloroplasty or Jadd excision of an ulcer on the anterior wall. It is advisable to suture or excise an ulcer with pyloroplasty accompanied by vagotomy that normalizes the acid-proteolytic activity of gastric juice in the postoperative period and eliminates need for antisecretory drugs to prevent the recurrence of the disease.