A RARE CASE OF ACUTE PERFORATION OF GASTROJEJUNAL ULCER

General Surgery

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ABSTRACT

Gastrojejunal anastomotic complications are frequent and occur within the first days or upto several years after surgery. Marginal ulcers occur after gastrojejunostomy or gastrectomy of the Billroth II type. The jejunal loop is exposed directly to the gastric acid, so the ulcer is usually found on the jejunal side of the stoma. Anastomotic site leak, hemorrhage and stomal stenosis are well known complications of gastrojejunostomy but ulcer perforation is a rare entity.

KEYWORDS:

Oral health, Oral hygiene Index, Rural, Students

Introduction

Marginal ulcer are multifactorial, the development of early marginal ulcer is more likely associated with local factors (ischemia, postoperative inflammation, stenosis, and foreign body) while marginal ulcer are likely to be related to an increased acid exposure of the gastrojejunostomy developing over time1-2. Gastrojejunal stomal ulcer is commonly found on the jejunal side of the stoma3 due to direct exposure to gastric acid. NSAID and smoking also increase the risk of ulcer formation4. These patients may present with upper G.I. bleeding because of hemorrhage from the ulcer site or with perforation, which is very rare.

Case report

A 55-year-old male chronic smoker and alcoholic presented with pain in the upper abdomen for 4 days with two episode of vomiting and slight abdominal distension not passing flatus for one day. He had swallowed one tablet combiflam (ibuprofen + paracetamol). There was no history of trauma, fever and chest pain. Ten years before, closure of a large perforated ulcer of duodenum.

On admission, temperature was 99.4ºF, pulse 110/min., respiration rate 20/min. and B.P. 110/74mmHg. On examination, there was a vertical midline scar mark present . The whole abdomen was distended and tender. Muscle guarding, rigidity and rebound tenderness was present over the whole abdomen with obliterated liver dullness. Bowel sounds were absent. Hernial orifices and genitalia were normal. P. R. examination was normal. Chest x-ray showed free gas under the right dome of the diaphragm. After initial resuscitation, the patient was shifted to the operating room for exploratory laparotomy. Right upper midline laparotomy was done. On exploration, there was a small (0.5x0.5cm) perforation at the efferent jejunal side of the old gastrojejunostomy. The perforation was repaired and reinforced with a tag of omentum. Ryle's tube was placed in the efferent loop. Thorough peritoneal lavage was done and two intraperitoneal drains were placed. The course was uneventful postoperatively.

Discussion

In the past, vagotomy and gastrojejunostomy or pyloroplasty were the standard treatment for peptic ulcer disease. Laparotomy and closure of perforation with reinforcement with omental patch still remains the treatment of choice for perforated peptic ulcer. Stomal ulcers are very infrequently seen today as the numbers of vagotomy and medical treatment has been introduced successfully.

In the majority of cases, gastrojejunal ulcer is anastomotic. But in our case, the ulcer was on the jejunal side of the old gastrojejunalostomy on the efferent loop of the jejunum, close to the anastomotic site.

Figure 1 X-ray chest showing gas under right dome of diaphragm

Figure 2 X-ray abdomen
References


