THE TREATMENT OF UNCOMPLICATED DUODENAL ULCER AN UPDATE

Essay

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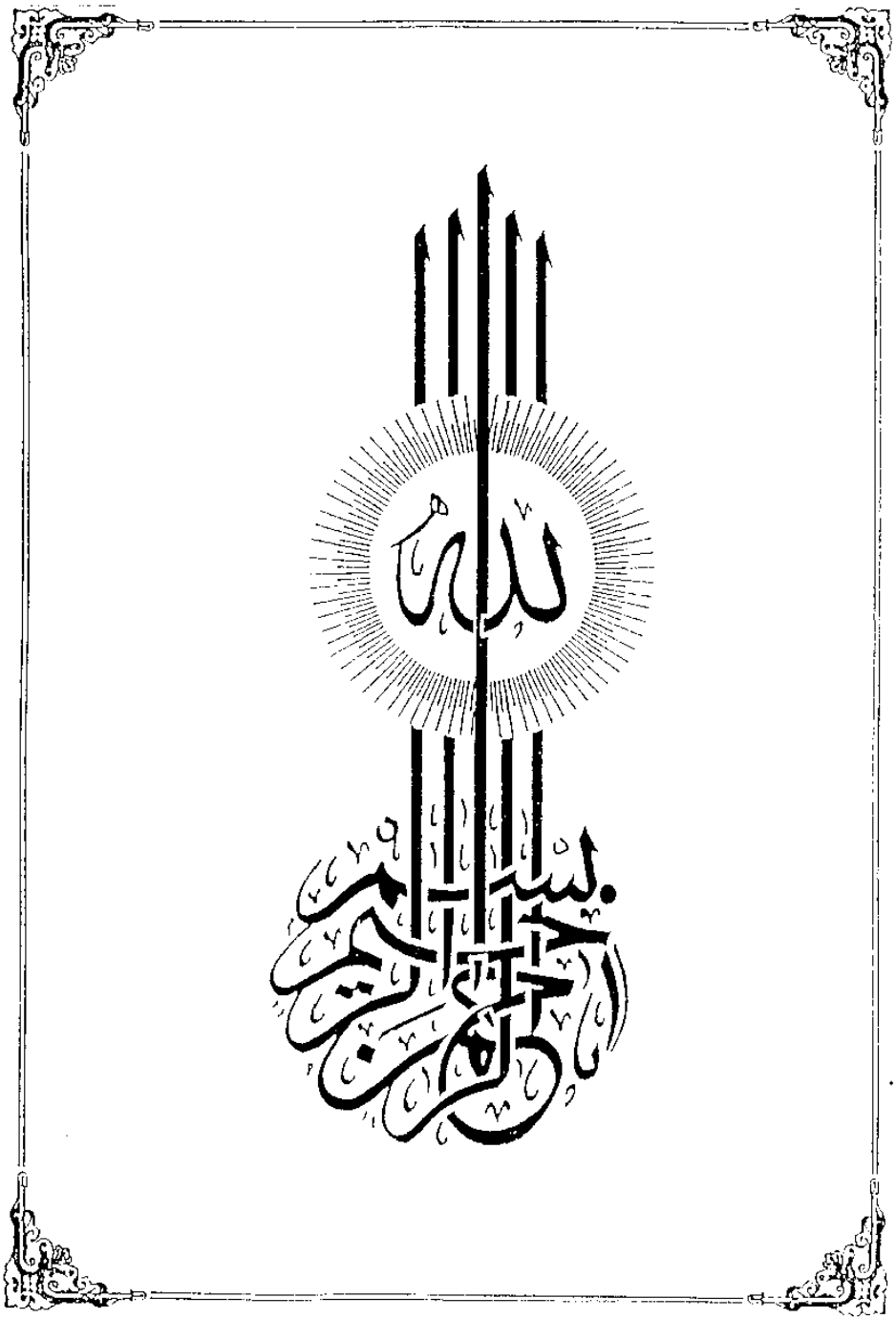

بسم الله الرحمن الرحيم

"وقل اعملوا فسيرى الله عملكم
ورسوله والمؤمنون"

صدق الله العظيم

التوبة الآية (١٠٥)

Dedicated

To

My Parents

who gave

too much and received

too little

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INTRODUCTION

INTRODUCTION

Duodenal ulcer is one of the most common disorders of the gastro intestinal tract. Fortunately, duodenal ulcer has relatively low mortality rate but high rate of disability and is responsible for great cost to society in loss of productive time and medical care (Thompson, 1991). Chronic duodenal ulcer afflict many people all over the world and the surgeon occupies a central place in the management of this disease and its complications (Taylor et al., 1985).

The development of surgery for duodenal ulcer is closely linked with the growth of knowledge over the last century of anatomy and physiology of the stomach. Hence surgery of duodenal ulcer had passed into stages of refinement starting by gastrectomy with high mortality rate and high rate of post gasterctomy sequelae and ending by conservative and more physiological procedures as highly selective vagotomy (Jorden, 1991).

The aim of surgery is to creat a safe operation and to avoid the post vagotomy sequelae. So, vagotomy has become more refined, selective and more time consuming. Attempts to interrupt the vagal fibres not outside the stomach but actually within the stomach wall has been envolved (Johnston, 1990 and Kelly, 1991). So, lesser curve seromyotomy has been used in man by Taylor in 1980 (Taylor et al., 1985). Immediate and longterm results of anterior seromyotomy and posterior truncal vagotomy are comperable with those of highly selective vagotomy (Siriwardena and Gunn, 1989).

The aim of this essay is to display the present day state of highly selective vagotomy and compare it with the results achieved by the medical control of this disease.