RECURRENT PEPTIC ULCERATION

ASSAY
Submitted for Partial Fulfillment of
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In
GENERAL SURGERY

BY

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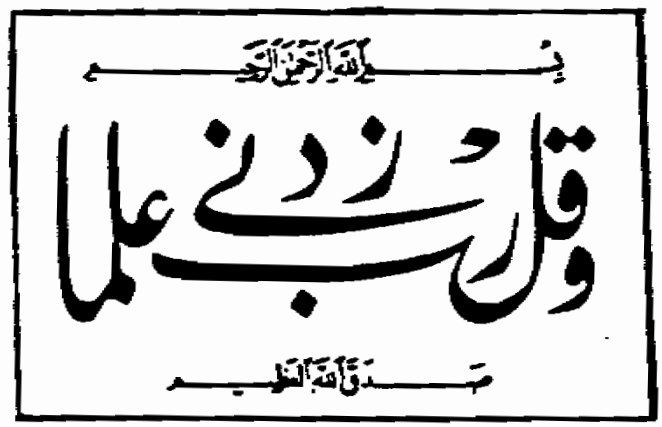

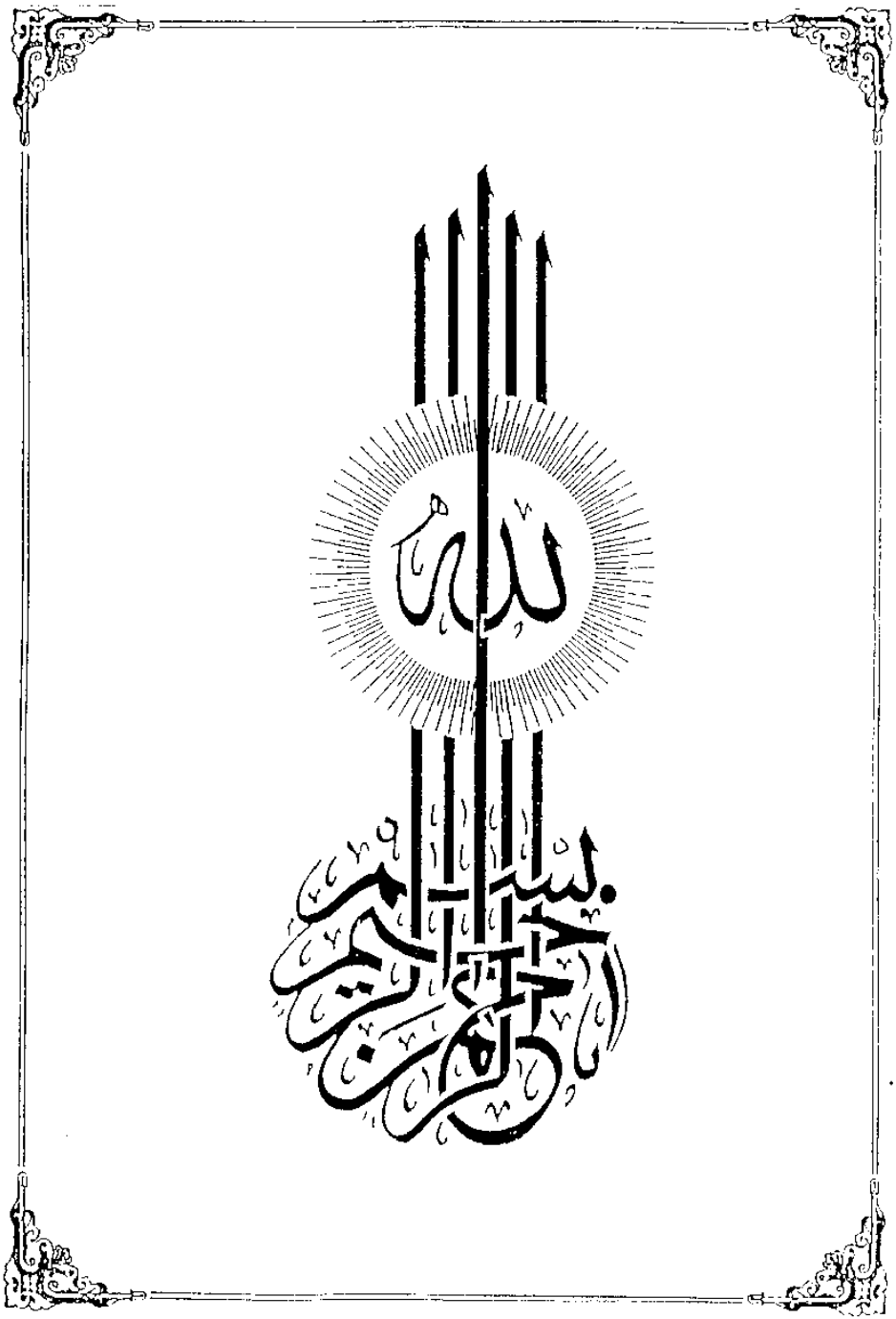

TO THE MEMORY OF
MY FATHER
MY FIRST TEACHER IN LIFE

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INTRODUCTION AND AIM OF THE WORK

INTRODUCTION

Peptic ulcer is one of the most common illness attributed to gastric dysfunction.

Modern drugs such as cimetidine, ranitidine and famotidine usually allows ulcer healing, but surgical treatment is both more effective and more specific than medical treatment.

The surgical treatment of peptic ulceration has many early and late complications, but the recurrent peptic ulcer is still the most important and most serious late complications **(Andros, 1967).**

Recurrent ulcers are in general, far more trouble some symptomatically than primary peptic ulcers, and they may give rise to considerable problems in diagnosis and treatment **(Kennedy, 1980).**

THE AIM OF THE WORK:

The aim of the work are:

1. To provide information regarding the known aetiological factors in recurrent ulcer.
2. To suggest a method of evaluation of these factors.
3. The review the collected experience with recurrent ulcer.
4. To recommend specific theraputic approaches based on the clinical experience.

ANATOMY OF THE STOMACH

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The stomach is the dilated first part of the gastro-intestinal tract.

Shape and position:

The shape and position of the stomach vary considerably, tending to be short, high and transverslaly oriented in broad individuals (Steerhorn-shaped stomach), and elongated and vertically oriented in thin individuals (J-shaped stomach).

Its position is also influenced by its degree of distention and that of other viscera, by posture, and by respiration. It is situated in the upper left portion of the abdominal cavity partly occupies the left hypochondrium, epigastrium and umblical regions **(Cunningham , 1981).**

Capacity:

Its mean capacity varies from 30 ml at birth, increasing gradually to about 1000 ml at puberty and commonly reaching to about 1500 ml in the adult **(Gray, 1980).**

Parts of the stomach:

The stomach consists of fundus. body, pyloric region it has two orifices, two "borders" or curvatures and two surfaces.

The funds:

Is that part extending above the cardiac orifice and coming in contact with the under surface of the left cupola of the diaphragm at the level of the fifth intercostal space, normally, in the erect position, it contains air, referred to as the "gas bublle".

The body:

Extends from the fundus to the level of the incisura angularis, a constant notch in the lower part of the lesser curvature **(Last, 1984).**

Pyloric region:

It consists of pyloric antrum, pylorus and pyloric canal.

The pyloric antrum:

It is the widest part of the pyloric region and narrows gradually towards the pyloric canal and pylorus.

The pylorus and pyloric canal:

The pylorus is palpably thicker than the rest of the stomach wall and the pyloric canal is held closed by tonus of the pyloric sphincter except when the latter relaxes to allow the stomach to expell a jet of its contents into the duodenum **(Last, 1984).**

When the pylorus was not readily located because of oedema or fibrosis, Mayo would describe its identification by a vein that

is quiet constant. This vein has been called the pyloric vein of Mayo.

Gastric Orifices:

1. Cardiac orifice:

The opening by which the oesophagus communicates with the stomach. It is situated on the left of the median plane, behind the seventh costal cartilage 2.5 cm (1 inch) from its junction with the sternum, and at the level of the eleventh thoracic vertebra. It is placed about 40 cm (16 inches) from the incisor teeth.

The right side of the oesophagus is continuous with the lesser curvature while the left side joins the greater curvature at an acute angle, termed the cardiac notch **(Gray, 1980)**.

2. Pyloric orifice:

It is the opening into the duodenum and its position is usually indicated by a circular groove on the surface of the organ, termed pyloric constriction, which indicates the position of pyloric sphincter. In the living subject, at operation, it can be identified by the pre-pyloric vein of Mayo.

The pyloric orifices lies in the recumbant position, at or slightly to the right of the midline on the transpyloric plane, opposite the first lumbar vertebra. It is more mobile than the cardiac orifice,

descending in the erect posture to the second or third lumbar vertebra and being displaced as much as 5 cm to the right when the stomach is full **(Cunningham, 1981)**.

The gastric curvatures:

1. **The lesser curvature:**

Extends between the cardiac end and pyloric orifices from the right (or posterosuperior border) of the stomach. It descends as a continuation of the right margin of the oesophagus and ends at the pylorus. The most dependant part of the lesser curvature form a notch called angular incisure.

The lesser curvature gives attachment to the lesser omentum, the two layers of which contain the right and left gastric vessels, adjacent to the lesser curvature.

2. **The greater curvature:**

It is directed antero-inferior, and is four or five times as long as the lesser curvature **(Gray, 1980)**. The greter curvature forms an acute permanent angle, the cardiac notch, with the left border of the oesophagus. It forms the left border of the stomach. At its lowest point, which in the J-shaped stomach distended with food may be considerably below the umblicus, it turns upwards and to the right to become continuous with the lower border of the duodenum, the greater curvature gives attachment to the gastro-splenic ligament on the left side of the fundus and the adjoining