Peptic ulcer disease

Professor Alaa El-Suity

Acute peptic ulcer

Troubles waste the stomach

like rust waste iron

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Pathology

- Abnormal sites
  Jejunum & oesophagus
  (+ Stomach & duodenum)

- Multple small superficial ulcers

Aetiology

1- Stress
2- Steroids & NSAIDs
3- Surgery (prolonged surgery, neurosurgery)
4- severe trauma
5- severe sepsis
6- severe burn

Clinical features

- Acute epigastric pain
- Vomitinig & haematemesis
- Perforation (may be)
- Burn → Curling ulcer
- Neurosurgery → Cushing ulcer

"After every end is a new beginning, and every beginning has an end"

Clinical presentation of chronic peptic ulcer

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Clinical Presentation

- Patients present with dyspepsia, epigastric pain and or discomfort. Acid may irritate nerve endings or peristaltic waves passing the ulcer may cause discomfort.
- But there is great overlap in symptoms with non ulcer dyspepsia. 20% of patients will present with serious complications without previous ulcer symptoms.
- It is said that gastric ulcers present with pain associated or closely followed by eating ,where-as duodenal ulcer pain is relieved by food.

Clinical Presentation

- These two pain processes are very non specific.
- Pain tend to be chronic and recurrent. The two can generally not be differentiated on clinical grounds alone.
- Generally gastric ulcers present from age 50-65, where as duodenal ulcers present in the thirties.
- Other non specific symptoms are nausea, weight loss, heart burn fatty food intolerance and bloating.
- Melena alone more frequently associates duodenal ulcers. Gastric ulcers present with hematemesis or melena in equal frequency.

Clinical Presentation

- Ulcers may also present with a perforation. This occurs in 5-10% of patients.
- Gastric outlet obstruction usually develops in the context chronic ulcer disease. Seen in <5% of patients.

Duodenal versus Gastric ulcers

Gastric	Duodenal
Normal/hypo-secretion of gastric acid	Hyper-secretion
Pain 1-2 hrs pc meals	Pain 2-4 hrs pc meals
Food aggravates pain	Food may relieve pain
Vomiting common	Vomiting not common
More likely to hemorrhage – manifests as hematemesis	Less likely to hemorrhage, but if occurs, likely to manifest as melena

Diagnosis of chronic peptic ulcer

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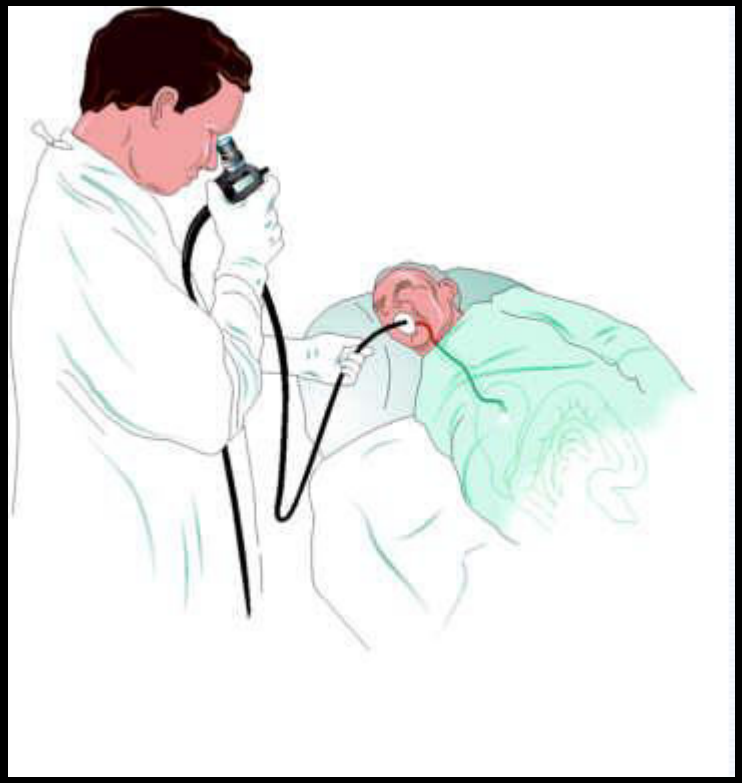
1) Esophagogastroduodenoscopy

- Fiberoptic endoscope allows direct visualization of esophagus, stomach and duodenum

- Biopsy
  → detection of H.pylori
  → Malginancy in gastric ulcer



Complications of duodenal ulcers

1) Haemorrhage
2) Perforation
3) Pyloric stenosis

Complications of Gastric ulcers

As above +

4) Hour glass stomach
5) Tea-pot stomach
6) Malignancy

Treatment of Peptic Ulcer

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“Choice not chance determines destiny”

الاختيار و ليس الحظ هو ما يُحدد المصير

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Medical Management of ulcers

- Conservative therapy:
  - Rest: Both physical and emotional
  - Dietary modifications
  - Elimination of smoking
  - Long term follow up care
- Pharmaceutical:
  - Antibiotics
    - To eradicate *H. Pylori* infections
    - Recurrence of ulcer is 75-90% as high with infection
  - Antiacids
    - Initial drugs of choice
  - Histmaine H2 receptor antagonists
    - Histamine is the final intracellular activator of HCL secretion
  - Anticholinergic:
    - Stop the cholinergic stimulation of HCl secretion and slow gastric motility
    - Not commonly used, if used need to be used with caution in pts with Glaucoma

Can you identify these people ?

Nobel prize Medicine – 2005

Discovery of H.pylori & its role in ulcer

Barry J Marshall

J. Robin Warren

Eradication of H.pylori

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Triple Therapy

- The BEST among all the Triple therapy regimen is

Omeprazole / Lansoprazole - 20 / 30 mg bd

Clarithromycin - 500 mg bd

Amoxycillin / Metronidazole - 1gm / 500 mg bd

- Given for 14 days followed by P.P.I for 4 – 6 weeks
- Short regimens for 7 – 10 days not very effective

Surgical Management of ulcerations

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