

Conservative Treatment Of A Circumscribed Perforation Of A Stomach Ulcer Into The Bursa Omentum Cavity

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Abstract

A case of intrabdominal abscess resulting from a ulcer perforation is reported. Conservative treatment was successful.

A 49 years old patient came to a doctor on the 5-th day of intensive pain in epigastrium. An endoscopy detected an ulcer on the small curvature of the upper third of the stomach. It was 3 cm in diameter, with undermined edges, and the deep bottom covered with fibrinous layers. Hyperemia, edema and infiltration in the area of the small curvature were also detected. There was not any cytological evidence of malignancy. The patient was hospitalized.

Anti-ulcerous treatment was started. The peripheral blood test revealed a strong decrease of the hemoglobin value to 6.7 g/dl and blood erythrocytes $2.4 \times 10^{12}/l$. The pancreas ultrasonography did not reveal any pathology. On day 7, the stomach X-ray detected an accumulation of the contrast substance in the region of the small curvature. The fluid collection reached into the bursa omentum with a narrow sinuous course ending into a "cul-de-sac" measuring $9 \times 3 \times 3$ cm in size. A horizontal level of a liquid could be detected (see Photo 1).

Figure 1

Photo 1. The stomach roentgenogram: The abscess cavity is contrasted.



On day 9, a second endoscopy revealed a fistulous hole with a large amount of pus entering the bottom of the ulcer. The ulcer was cleared from fibrin. The attempt to drain the purulent cavity via a nasogastric tube was not successful.

The catheter could not be held long enough in the correct area. The results of the examination described above gave grounds to assume that the abscess was due to ulcer perforation. The absence of sepsis and peritonitis, and the decrease of pain, led us to the decision to continue conservative treatment.

De-NoL, Omeprazole, Maalox and antibiotics were prescribed, - periorally and intramuscularly. 1 unit of packed red cell blood was transfused; the laboratory parameters normalized subsequently. The abscess cavity lavage was performed during therapeutic endoscopies using antiseptic solutions.

After 20 days of the treatment a scar developed in the area of the former ulcer and the infiltration decreased. The fistulography showed that the abscess cavity had decreased

three times in size.

The patient was discharged and seen as an outpatient. After two months, a control endoscopy showed that the ulcer had closed completely. The stomach roentgenoscopy did not reveal any contrast accumulation. Ultrasonography did not detect any traces of liquid accumulation where the abscess had previously developed and did not detect any other pathology. The patient recovered.

We have not found any description of similar clinical observations in the literature. It is our opinion that conservative treatment of complications of a peptic stomach ulcer is possible and can be effective if a patient has no peritonitis symptoms.

References

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