INTRODUCTION
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Peptic ulcers are most often solitary chronic lesions that occur at any level of GI tract exposed to aggressive action of acid peptic juices or a decrease in the mucosal resistance.

An ulcer is defined as a persistent discontinuity of an epithelial surface that can occur in skin or mucus membrane. Peptic ulcers are so common in industrialized nation that they virtually represent stigma of civilization.

Perforation is one of the most catastrophic complications of peptic ulcer. In spite of modern advances in surgical, anaesthetic and ancillary facilities, it still assumes life-threatening dimensions. Prompt recognition of the condition is of paramount importance, as only by early diagnosis and treatment it is possible to reduce the still relatively high mortality.

Approximately 98-99% of peptic ulcers either in duodenum or in stomach in ratio of 4:1. Duodenal ulcer is the most common ulcer in the GI tract. Free perforation into the peritoneal cavity occurs in 2-3%. Perforation of duodenal ulcer is an emergency condition, which requires immediate surgical intervention. Peptic ulcers are remitting and relapsing lesions that are often diagnosed in middle aged to older adults (45 yrs. and above). 5-10% of
patients have no recognizable prior ulcer symptoms and may appear after a period of weeks to months of active disease and heal with or without therapy. Thus it is difficult to express accurate data about frequency of active disease. The best estimate of peptic ulcer frequency is from autopsy studies and surveys of patients indicate a range of 6.14% for men and 2.6% for women. Perforation is one of the most dramatic complication of duodenal ulcer and perforated duodenal ulcer is most common perforation of upper GI tract. Ulcer that perforates mostly present on anterior aspect of first part of duodenum, rarely an ulcer is present in posterior wall and perforates in lesser sac and adjacent structures, most often in pancreas, less commonly into liver, biliary tract or colon.

It is silent chronic ulcer that perforates specially in patients who are being treated with steroids, usually symptoms of perforation occur with dramatic suddenness.

After perforation duodenal contents escape through the perforation into general peritoneal cavity resulting into the peritoneal reaction (Peritonism). Peritoneum reacts to this chemical irritation by secreting peritoneal perforation fluid copiously, which dilutes the contents, and this gives relief of pain
for short time. This stage lasts for 3-6 hrs and is followed by diffused bacterial peritonitis.

Bacterial peritonitis develops late as there is sufficient acid from the stomach. If this condition is not treated immediately, the course is fatal. Patients die because of septicemia and peripheral vascular failure.

If early treatment is instituted in form of surgical closure of perforation, through peritoneal lavage I.V. fluids and parenteral antibiotics, mortality is low. Various methods have been adopted for closure of perforated duodenal ulcer from time to time and superiority of method is judged in terms of incidence if post operative leakage. The options available for closure of perforated duodenal ulcer include simple closure, Cellan Jones closure, closure by falciform ligament and Grahm's closure.

The present study deals with the:

1. Age distribution
2. Sex distribution
3. H/O smoking and its duration
5. Psychological factors (stress/anxiety)
6. Family history
7. History suggestive of chronic gastric/ duodenal ulcer, Diabetes, Hypertension
8. Symptoms
9. Clinical signs elicited
10. Radiological features
    • X-Ray abdomen findings
    • USG findings
11. Procedure performed
    • Surgical
    • Conservative
12. Total hospital stay
13. Post operative Complications
    • Fever
    • Wound sepsis
    • Wound dehiscence
    • Leakage/duodenal fistula
14. Other complications
    • GOO
    • Pulmonary
    • Cardiovascular
    • Renal
15. Mortality