Duodenal ulceration

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- Incidence There have been marked changes in the demography of patients presenting with duodenal ulceration in the West. In part, this may relate to the widespread use of gastric antisecretory agents and H. pylori eradication therapy in patients with dyspepsia. Second, the peak incidence is now in a much older age group and, although still more common in men, gender di ff erence is less marked. These changes mirror the changes, at least in part, in the epidemiology of H. pylori infection. In eastern Europe, - the disease remains common, and the incidence is rising in resource-poor nations. Pathology Most ulcers occur in the first part of the duodenum (Figures 67.10 and 67.11). A chronic ulcer penetrates the mucosa into - the muscle coat, leading to fibrosis. The resulting scarring may cause a deformity such as pyloric stenosis. When an ulcer heals, a residual scar can be observed in the mucosa. Sometimes there may be more than one duodenal ulcer. The situation in which - there is both a posterior and an anterior duodenal ulcer is referred to as ‘kissing ulcers’. Anterior ulcers tend to perforate

Figure 67.10 Duodenal ulcer at gastroduodenoscopy (courtesy of Dr GNJ Tytgat, Amsterdam, The Netherlands).

while posterior duodenal ulcers tend to bleed, sometimes by eroding into the gastroduodenal artery . Occasionally , the ulceration may be so extensive that the entire duodenal cap is ulcerated and devoid of mucosa. With respect to the giant duodenal ulcer, malignancy in this region is so uncommon that under normal circumstances surgeons can be confident that they are dealing with benign disease, even though from external palpation it may not appear so. In the stomach the situation is di ff erent.

Figure 67.11 Duodenal ulcer shown by barium meal.

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