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TREATMENT OF PATIENTS WITH PEPTIK ULCER OF THE STOMACH AND DUODENUM IN A POLYCLINIC

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Abstract:

In the article "Treatment of patients with peptic ulcer of the stomach and duodenum in a polyclinic" reports on the results of outpatient treatment of patients with peptic ulcer using the original method proposed by them - endoscopic autohemoapplication (EAGA) of ulcers.

Keywords: *peptic ulcer disease, endoscopic autohemoapplication of ulcers, outpatient treatment*

RELEVANCE. Patients with stomach ulcers and duodenal ulcers make up a significant portion of visits to a gastroenterologist, and it must be admitted that they often seek referral to a hospital for inpatient treatment. This tradition has been established not only in the minds of patients, but also in the minds of local doctors. This is due to the "gray" nature of treatment with oral medications, which have lost their appeal among the population compared to infusion therapy. However, there are effective methods for treating this condition, and their implementation can significantly improve the outcomes of conservative therapy and increase patient trust in outpatient care.

The purpose of this article is to familiarize polyclinic practitioners with a new effective method of local therapy for chronic gastroduodenal ulcers in the complex treatment of peptic ulcer disease.

MATERIALS AND METHODS. In the polyclinic conditions, 161 patients with uncomplicated chronic duodenal ulcers were performed EAGA of the ulcer in the complex of anti-ulcer therapy. Of them, 126 were men, 35 – women. There were 3 patients under 19 years old, 106 aged 20-44 years, 39 aged 45 - 59 years, 11 aged 60 - 74 years and older - 2 patients. All patients presented with exacerbated peptic ulcer disease with duodenal ulcer localization. Of these, 23 patients presented for the first time, while the remaining 138 patients presented after undergoing conservative treatment at their place of residence, which proved to be ineffective.

During endoscopic examinations, the following was found in these patients: 31 patients had a ulcer on the anterior wall of the duodenal bulb, 6 patients had a ulcer on the upper wall, 15 patients had a ulcer on the posterior wall, and 8 patients had a ulcer on the lower wall. 47 patients had a ulcer on the anterior-upper wall, 17 patients had a ulcer on the posterior-upper wall, 2 patients had a ulcer on the posterior-lower wall, and 10 patients had a ulcer on the anterior-lower wall. One patient had a ulcer on the pylorus ring. 17 patients were diagnosed with "kissing" ulcers, and 7 patients had an ulcer in the postbulbar part of the duodenum. The size of the ulcer in 138 patients did not exceed 1 cm, and in 23 patients it was slightly more than 1 cm. in diameter. Only one patient had a chronic ulcer on the anterior-upper wall of the duodenal bulb with dimensions of 2x1 cm.

The technique of performing endoscopic autohemoapplication: the patient's position on the right side is on the "ulcer side". Esophagogastroduodenoscopy is performed in the usual manner. The amount of blood previously taken from the ulnar vein of the patient is quickly injected with a syringe 5-6 ml., aiming at the ulcer crater. The endoscope is removed. The patient does not change his position for 8-10 minutes. Meal intake in 0.5-1 hour. All patients received 20 mg of quamatel tablets twice a day, in the morning and in the evening, for two weeks.Results and discussion.

After the main mechanism of ulcer chronication and the development of a periulcerous inflammatory infiltrate around the ulcer was identified, the morphological features of chronic gastroduodenal ulcers and the role of gastric juice infiltration through the ulcer defect in the development of hyperchlorhydria were examined. It seems necessary, along with measures to suppress the acid-secretory function of the stomach, to use local therapy methods that help stop gastric juice infiltration through the ulcer, taking into account the identified morphological features of chronic ulcers [3].

There is a known method of treating gastric and duodenal ulcers, which consists in applying ulcers with film-forming polymer solutions (lymphosol, gastrozol, glue MK-6, MK-7, MK-8) using an endoscope [2, 1]. The disadvantages of this method are the great technical

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difficulties in performing the application associated with possible premature polymerization of the substance in in the catheter, or in the endoscope channel when moisture from the stomach and duodenum enters the lumen, as well as the complexity of preparing (cleaning, draining) the ulcerative surface for strong adhesion to the polymer substance.

Due to the fragmentation and detachment of the polymer film from the surface of the ulcer after 2-3 days (and in case of violation of the surgical technique immediately or within a few hours), it is necessary to reapply the substance through the endoscope. The use of acetone for quick washing of the catheter and the distal end of the endoscope contaminated with the polymer film is not safe for the expensive device. In addition, fast-hardening solutions do not have time to penetrate into the existing "pores" of the ulcer crater and form mainly a surface film. All of them are imported and not available to the general public, are expensive, and are purchased with foreign currency. A significant drawback is the foreignness of these polymers to the human body.

We needed an applicator that would not have the above-mentioned disadvantages. Given the clinical symptom of Bergman - the disappearance of pain sensations in the epigastric area, accompanying the exacerbation of peptic ulcer disease with bleeding from the ulcer, it was decided to use autologous blood as an applicator [4]. According to preliminary calculations, it should not have the disadvantages typical of polymers.

Immediately after the first EAGAs, 156 patients had their pain subside and their quality of life improved significantly. In 5 patients, although the epigastric pain became less intense, it did not completely disappear. Endoscopic follow-up showed that after the course of treatment, which consisted of 1-2 EAGAs of the ulcer, on average, about two weeks later, 129 patients had complete scarring of the ulcer. During this period, 18 patients experienced a significant reduction in the size of the ulcerative defect, and 7 patients achieved clinical remission, characterized by the disappearance of inflammatory infiltration of the duodenal mucosa surrounding the ulcer and concomitant duodenitis. In 6 patients, complete healing of the ulcer occurred within 3 weeks, and in 1 patient, it occurred within 4 weeks. Of the 161 patients, 5 patients who did not show complete clinical improvement after one [3] and two [2] EAGA sessions were hospitalized and operated on a week later. All of them underwent 2/3 stomach resection.

In the main group of patients, morphological studies of the removed duodenal ulcers were performed at various times (from 1-2 days to 1 week) after a single endoscopic autohaemostasis. When examined by light microscopy 1-2 days after EAH, the morphological structure of the ulcers was almost identical to that of the ulcers in the control group. There is a pronounced infiltration of the ulcer bottom tissue with neutrophilic polymorphonuclear leukocytes, which indicates a significant degree of inflammation in all layers of the duodenal wall near the ulcer defect. However, in most cases, there is a slight decrease in the degree of interstitial edema. There are blood clots on the surface of the ulcer crater, and blood cells (mainly erythrocytes) are penetrating into the microcracks of the ulcer wall.

There is a concentration of blood cells not only in the immediate vicinity of the ulcer surface, but also in more distant areas.

Morphological studies of biopsy material during repeated gastroduodenofibroscopy and removed ulcers in 5 operated patients showed that after the course of EAGA, there were some structural differences in the morphology of chronic duodenal ulcers compared to those in patients who were operated without EAGA in the preoperative period from the control group. It was found that the layer of tissue detritus covering the bottom of the unhealed ulcers was significantly thinner or absent altogether, and the infiltration of all layers of the ulcer by neutrophilic polymorphonuclear leukocytes was significantly reduced, and the leukocytic вала was almost absent.

In the deeper tissues of the ulcer bed, the degree of inflammatory infiltration decreased. It was mainly composed of macrophages and lymphoid cells. Neutrophilic polymorphonuclear leukocytes were present in small numbers.

In the areas of the peritoneum located in the projection of the ulcer defect and in the adjacent regions, the inflammatory phenomena were also reduced compared to the control group (Fig. 7). In most patients, histological examination revealed complete epithelialization of the ulcer bed.

Thus, in a group of patients with gastric and duodenal ulcers (with chronic duodenal ulcers in the exacerbation stage), who did not have indications for surgical treatment, the combined use of EAGA in 80.12% of cases led to complete scarring of the ulcer within an average of 2 weeks. In 4.35% of patients, the ulcer scarring occurred after 3-4 weeks from the start of treatment. In 11.18% of patients, there was a significant decrease in the size of the ulcer, and in only 4.35% of patients, although the clinical symptoms of the disease disappeared, the size of the ulcer did not change. The experience of using EAGA for ulcers has shown the effectiveness of using them in combination as an independent method of treating uncomplicated

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forms of gastric and duodenal ulcers with duodenal localization, as well as in the context of preoperative preparation for patients with potential "difficult" duodenal ulcers.

CONCLUSION. 1. The use of endoscopic autologous blood application of the ulcer
in patients with uncomplicated forms of peptic ulcer in polyclinic conditions against the background of drug therapy significantly improves the results of treatment and the quality of life of patients.

2. The therapeutic effect of EAGA of the ulcer is due to the coating of the blood thrombus of the ulcer crater and the penetration of blood into the micro-slits of the ulcer wall
with subsequent thrombi, leading to the cessation of infiltration of gastric juice into the depth of the duodenal wall.

3. The technique of EAGA is simple and does not actually require additional funding.

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