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Available online at: http://www.iajps.com ***Research Article***

A COMPARATIVE STUDY ON THREE DIFFERENT YOUNG MALE PATIENTS DIAGNOSED WITH DUODENAL ULCER AND TREATED WITH APPENDICITIS

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Abstract:

This report is about three cases of male patients with young age. These patients were detected with perforated duodenal ulcer. With appendectomy, it was treated as appendicitis. Treatment was done on the basis of detection. These patients spent a long period of time in the Hospital due to the wrong perception. If the pre-operative findings, history and examination are taken attentively, this problem could have been prevented. The results of these situations are not adverse if treated with an appendectomy. However, appendicitis may be similar to surgical pathology somewhere in abdomen. Surgeon may not be able to observe the area of primary pathology due to cut in traditional right lower quadrant. Appendectomy is carried out mistakenly by the operator if appendix is present in the peritoneal inflammatory response detection of the primary pathology delays and so does the treatment. It results in drastic results. Appendectomy along with perforated duodenal ulcer present one such case. In 1926, Rudolph Valentino, a famous American film actor, died because of complexities which included perforated duodenal ulcer. This was treated with appendectomy and defected wrongly.

Keywords: *Duodenal Ulcer, Appendicitis.*

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INTRODUCTION:

Among the usual surgical emergency situations, appendicitis is the one [1]. Clinical detection is the appropriate base for diagnosis up till now. A little investigation support is involved in this detection [2, 3]. There involved well-known defects in this approach. In young ladies, the chance of high disorder is always high. However, in history, the significant negative appendectomy rate changes from 9-20% [4]. In history, pathology is a similar problem which is not mesenteric adenitis etc are non-surgical situations related to appendicitis. The results of these situations are not adverse if treated with an appendectomy. However, appendicitis may be similar to surgical pathology somewhere in abdomen. Surgeon may not be able to observe the area of primary pathology due to cut in traditional right lower quadrant. Appendectomy is carried out mistakenly by the operator if appendix is present in the peritoneal inflammatory response detection of the primary pathology delays and so does the treatment. It results in drastic results. Appendectomy along with perforated duodenal ulcer present one such case. In 1926, Rudolph Valentino, a famous American film actor, died because of complexities which included perforated duodenal ulcer. This was treated with appendectomy and defected wrongly [5]. In this study, we present 3 cases. The time duration was three years. These cases were conducted at a tertiary care Hospital.

CASE – I:

This case was about a male patient whose age was 30 years old. After an open appendectomy technique, for three days, the patient was admitted to the emergency room (ER). The patient was suffering from high-grade fever, continuous abdominal discomfort and vomiting. The indications of peritonitis, tachycardia and dehydration were illustrated through examination. A perforated duodenal ulcer (DU) was observed at laparotomy. A computed tomography (T) scan was carried out. Through this, oral contrast spillage is being observed in the duodenal area. The patient was ventilated for two days after the operation. After 12 days of operation, the patient was able to intake anything and then discharged.

CASE – II:

In this case, the male patient was presented with age 48 years old. He was suffering from pain and abdominal discomfort. Seven days before the admission of the emergency room, the patient was examined. On examination, the patient was observed with febrile and tachycardia. A perforation in the duodenum was revealed through laparotomy. From the injured through laparotomy. From the injured area, three observed an excretion of bilious. These showed the symptoms of appendectomy and laparotomy and graham patch repair was carried out. After the operation, the patient was given with ventilation. The patient was able to consume anything orally. There was a requirement of care for the injured area of the patient. After 13 days of operations, the patients were discharged.

CASE – III:

This case was about a male patient whose age was 28 years old. He was suffering from vomiting and abdominal pain distention. After 10 days of experiencing appendectomy, the patient was shifted to the emergency room. A perforated DU was observed at laparotomy. The patient was examined and found with septic shock with the indications of peritonitis. The patient showed a complex recovery. The patient was provided with ventilation for 5 days and then discharged. After 6 months, the incisional hernia was needed.

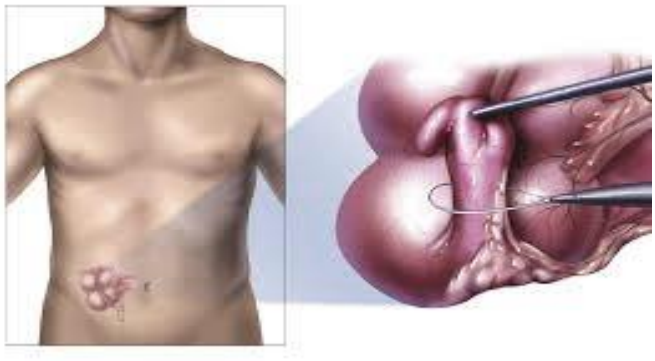

Figure – I: Appendectomy

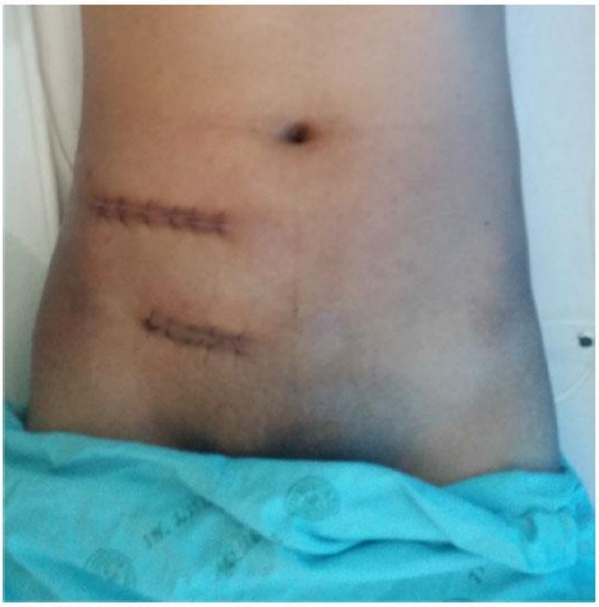

Figure – II: Stitched After Open Appendectomy Technique

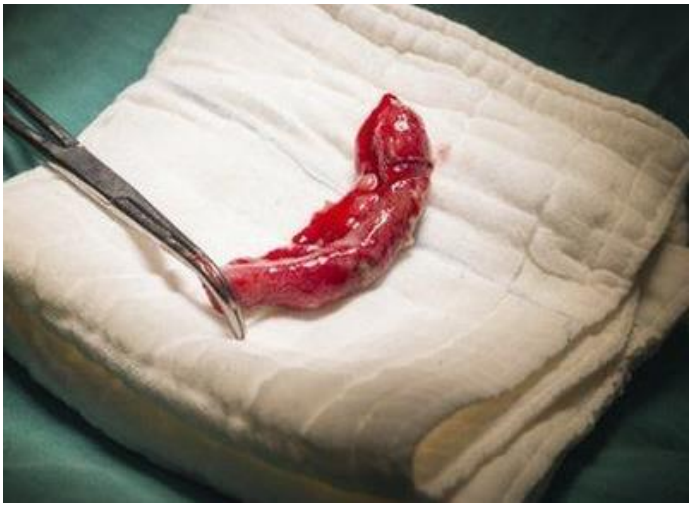

Figure – III: Removed Appendectomy

DISCUSSION:

Among the usual surgical emergency situations in young adults, acute appendicitis is the one, depletion can be observed in a demonstration of peri-umbilical discomfort switching to right iliac fossa with variable features. The insufficient investigation, unusual demonstration or changes in the clinical demonstration may contribute to this issue. Appendicitis was difficult to identify an an emergency room. When a perforated DU is indicated wrongly as appendicitis, in this condition, valentine appendix is well-narrated. Prior to the physical assessment of the patient, the significance of careful history-taking is illustrated by this unusual framework. In appendicitis, two clear routes of pain are involved. So, the progression of pain has a clear arrangement. Due to the activation of the visceral pain pathway, the starting pain occur. From a mid-gut derivative, the pain pathway begins. Principal pain type becomes corporal if there is involvement of inflammation in the peritoneal surface of the appendix. For the purpose of indication, the variation in location and feature is significant, this is referred to as the migration of pain. The discomfort is very identical if because of the perforation of a DU. In some patients, the abdominal discomfort is long-lasting. There observed complexities in the beginning of this sudden

event. From the start, the pain of perforation is somatic. When the peritoneal cavity is exposed to irritant upper gastrointestinal contents, the pain of perforation results. There observed no variation of pain feature. If the surgeon encountered bile stained contents in right lower quadrant incision for an appendectomy. By means of upper midline incision, to undertake a formal laparotomy would be a secure thing in presence of such incidence. The reverse conversion would be another secure approach [6]. In future, there is a chance of reduction of low incidence of missed perforated DU.

CONCLUSION:

Among surgical emergency situations, the most common is appendicitis. On the basis of physical and clinical assessment, the disorder is identified. Perforated DU is a similar situation to appendicitis. Through right lower quadrant incision, surgeon experiencing appendectomies should distrust perforated DU. This will happen if the surgeon in presence of non-perforated appendix experience bile-stained fluid in the peritoneum.

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