AAST Acute Care Surgery Didactic Curriculum

Ulcer Disease

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Highlights:

- Perforated peptic ulcer disease
    - Broad spectrum antibiotic therapy to target gram negative, gram positive and anaerobic bacteria should be administered until source control is obtained. Empiric antifungal coverage is not required unless specific patient situations demand otherwise (i.e., immunocompromised, advanced age, etc.).
    - Operative management (over endoscopic or non-operative) remains the standard of care of perforated peptic ulcer disease.
    - Non-operative management of perforated ulcers maybe considered in non-toxic patients in whom there is evidence that the perforation has sealed.
    - Patient mortality increases significantly with hour by hour delay in achieving source control.
    - Laparoscopy (or robot-assisted laparoscopy) is a safe and reasonable approach in stable patients.
    - In perforation <2cm, primary repair +/- patch repair is recommended. In perforation >2cm, primary repair with patch will likely not suffice and other options including partial gastrectomy, duodenostomy, pyloric exclusion, etc must be considered depending on the situation.
    - Consider biopsy to rule out malignancy and H pylori testing.
- Hemorrhagic peptic ulcer disease
    - Reversal of coagulopathy and resuscitation with blood products in a balanced fashion is key.
    - Upper endoscopy plays a critical role in diagnosis of the etiology of upper GI bleed and assists in determining prognosis and risk of rebleeding. Consider pre-endoscopy erythromycin.
    - In cases of recurrent bleeding, endoscopy remains first-line treatment for diagnosis and intervention. Consider angioembolization if available after two endoscopic attempts.
    - Unstable patients require operative intervention for hemorrhage control.
    - Consider biopsy to rule out malignancy and H pylori testing.
    - Avoidance of NSAIDs and PPI therapy x 6-8 weeks is recommended.
- H pylori infection should be treated with standard triple therapy including PPI BID.