

An exact exceptional Judgement for Oldness, Complicated Gastric Ulcer in a 5 years old male: A case report

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Abstract

This article base on SCARE standards. Perforated gastric ulcer (PGU) is exceedingly uncommon in children. In a child with acute abdomen and Pneumoperitoneum, an appendicular etiology is more often suspects as a likely cause. Failure or delay to diagnose a PGU can result in significant morbidity and even mortality.

We report a 5 years old male with abdominal pain for 2 days with PGU. We do examination, and we find generalized abdominal pain and perform Laparotomy and we find perforated gastric ulcer and repair with Omental patch. PGU is an uncommon cause of peritonitis in children and poses significant challenges in management. Strong suspicion and prompt appropriate intervention is necessary to avoid untoward outcomes. Researchers conclude that GOO secondary to ulceration can occur in the absence of H. pylori infection. PPU is a rare cause of abdominal pain in children, but still a PUD complication that requires surgery. PPU should be included in the differential diagnosis in patients presenting with acute abdominal pain of uncertain etiology and pneumoperitoneum. Laparoscopy is both diagnostic and therapeutic. Laparoscopic omental patch repair is a safe and effective treatment for PPUs. This case illustrate that perforated peptic ulcers should be considered in children presenting with acute abdomen.

Keywords: Pediatric peptic ulcer disease, Pediatric Gastric perforation, Emergency surgery, acute abdomen.

Background:

Peptic ulcer disease (PUD) in children is unusual. Existing literature reporting a prevalence of 8.1% from Europe and incidence of 1.55 annual cases from India makes it an uncommon diagnosis (1, 2). Furthermore, even rarer are the complications of PUD such as perforation and hemorrhage. Radiological Pneumoperitoneum with peritoneal signs in a child should arouse a suspicion of PGU even though appendicitis considered the commonest cause of surgical abdomen in children (3). The aim of this case presentation is the perforated peptic ulcer is rare but can happen in children and illustrate that perforated peptic ulcers should be considered in children presenting with acute abdomen.

Case presentation:

My case was a 5 years old male with severe abdominal pain for 2 days before and admitted in surgical emergency part. At first, she was ill and toxic, tachycardia about 130/min and blood pressure was 90/60. In first step we hydrated patient, to stable her and then performed upright chest x-ray graphs and we saw the air below the liver bare area, and we Scheduled emergent surgery for her. We do laparotomy because we do not have enough time to perform laparoscopy and in another way place of ulcer is undiscovered for our team. We start surgery with a Midline classic Laparotomy and at this time, we find PUD (Figure1).

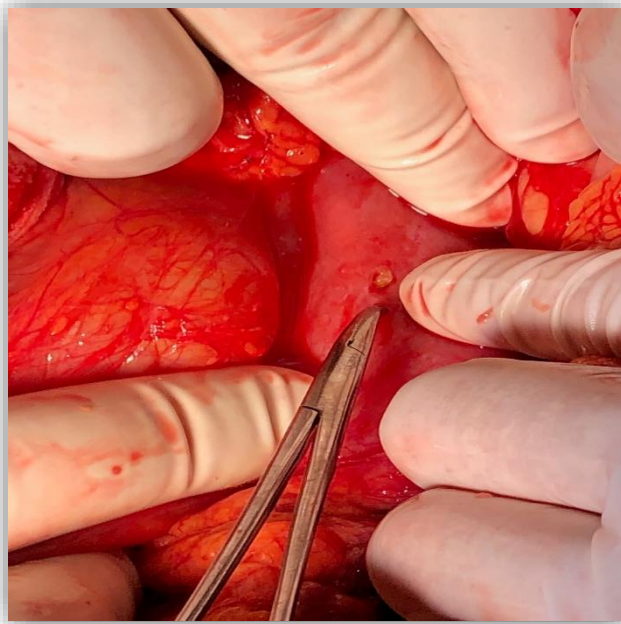


Figure 1: Perforated gastric ulcer

We wash a lot abdomen because of debris and clean around the ulcer, and get a lot sample of pathology according the data's.

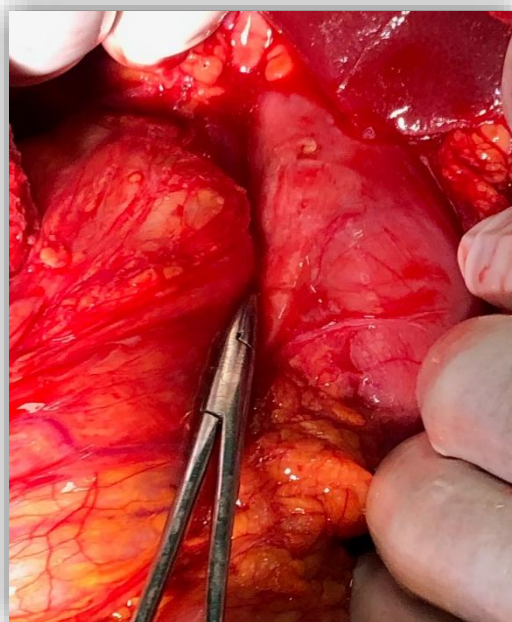


Figure 2: Perforated gastric ulcer

After that we repair the ulcer and we use omental patch, and after GI rest, we start eating fluids for patient and after rehabilitation successfully we discharge her healthy with PPIs and following the pathological specimens.

Discussion:

We know that PUD is an uncommon diagnosis in children with its complicated presentations being further rare. When a child with acute abdomen met with free intraabdominal

air on radiographs, PGU should be rule out as a possibility. Timely surgical intervention preceded by clinical suspicion is necessary to treat PGU and avoid the dreaded complications. Pneumoperitoneum and peritonitis following the perforation of a peptic ulcer is a rare cause of an acute abdomen in children and often results in a significant delay in diagnosis and subsequent operative management. This increases the likelihood of developing complications post-operatively (4, 5).

In the case we described, the underlying etiology related to H. pylori infection based on appearance of the stomach on endoscopy and positive serum IgG. Other described instances of perforation in Western countries implicate chronic steroid administration, NSAIDs, severe underlying illness, trauma, iatrogenic perforations from EGD, and air enemas in the radiologic reduction of intussusceptions(6,7,8,9,10,) The prevalence of H. pylori infection has declined in the United States and Europe. Despite this, the prevalence remains high in Asia and the developing world. Transmission occur most frequently from person-to-person, and children believed most commonly to acquire infection from their mothers. Most published studies demonstrate household crowding, sharing a bed with children, and sharing plates, spoons, or tasting food before feeding a child are related to infection in children.(9,11).

This case represents a rare entity in pediatric emergency medicine. The incidence of perforated peptic ulcer in children has been decreasing in industrialized countries. Peptic ulcer disease secondary to H. pylori infection is particularly important to recognize due to the high reported incidence of recurrence. Perforation from peptic ulcer disease treat with primary closure, omental buttress, and medical management of the underlying etiology (12). Short-term NSAIDs use in appropriate doses, commonly prescribed to control fever in children, can lead to PUD. Before administration, risk factors such as other antipyretic medication use or a suggestive familial history must consider (13). We conclude that GOO secondary to ulceration can occur in the absence of H. pylori infection (14). GOO secondary to PUD may occur in the absence of Helicobacter pylori infection (HPI) (15). A perforated gastroduodenal ulcer observed in children. Certain medications reported to cause ulcerations. Deferasirox, an iron-chelating agent, reported to be associated with the development of gastroduodenal ulcers (16). PPU is a rare cause of abdominal pain in children, but still a PUD complication that requires surgery. PPU should be included in the differential diagnosis in patients presenting with acute abdominal pain of uncertain etiology and pneumoperitoneum. Laparoscopy is both diagnostic and therapeutic. Laparoscopic omental patch repair is a safe and effective treatment for PPU (17). PUD is a rare disorder in childhood. There is no difference between H.Pylori related PUD and the others for clinical presentation, anemia or location of PU. For the discrimination of two groups, biopsy should take in all patients (18).

Pediatric acute abdomen, often limited by difficulties in history taking and nonspecific findings on physical examination, poses a significant challenge to the clinician(19). This case illustrate that perforated peptic ulcers should be considered in children presenting with acute abdomen (20). This kind of case is reporting in the world (21-25) and complication (26). We can see some problems as an edge of sciences(27-35).

Conclusion:

Pediatric acute abdomen, often limited by difficulties in history taking and nonspecific findings on physical

examination, poses a significant challenge to the clinician. This case illustrate that perforated peptic ulcers should be considered in children presenting with acute abdomen. PPU is a rare cause of abdominal pain in children, but still a PUD complication that requires surgery. PPU should be included in the differential diagnosis in patients presenting with acute abdominal pain of uncertain etiology and pneumoperitoneum. Laparoscopy is both diagnostic and therapeutic. Laparoscopic omental patch repair is a safe and effective treatment for PPU.

Declarations:

- Ethical Approval and Consent to participate:

The satisfied of this manuscript are in agreement with the declaration of Helsinki (last version) by the World Medical Association (WMA) for Ethics agreement.

No committee approval was required.

Oral and transcribed agreement to contribute accepted by patient family.

- Consent for publication:

Transcribed informed agreements obtain from the patient's legal guardian for publication of this paper and any associated images.

A copy of the written informed agreement is existing for review by the Editor-in-Chief of this journal.

- Availability of supporting data:

It is available.

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The author declares that they have no competing financial interests and nothing to disclose.

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- Authors' contributions:

Ahmad Reza Shahraki is the surgeon of patient and writes this paper.

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