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Correspondence

Letters to the Editor should not exceed 500 words.

Surgery for Perforated Duodenal Ulcer

SIR,—Mr. M. G. Machayya's careful study (19 October, p. 155) deals only briefly with two important matters in the surgery of perforated duodenal ulcer. He accepts Mr. J. A. Shepherd's (9 March, p. 625) statement on recurrence of symptoms after simple closure. Shepherd states that "it may be assumed that in any large series less than 25% of patients remain free from troublesome symptoms." From this, Mr. Machayya argues, it seems that every patient should have definitive surgery.

In 1953 I decided to test the theory that patients with perforated duodenal ulcer with a short history of indigestion probably had an acute ulcer which, if sutured, would give no further trouble, while those with a history of chronic indigestion could be assumed to have a chronic ulcer and should be treated by partial gastrectomy. This trial was continued for two years, during which 34 patients with a perforated duodenal ulcer were treated. Eighteen were considered to have an acute ulcer and had the perforation sutured, while 16 had a Polya gastrectomy for a chronic ulcer. One 87-year-old man died after simple suture. The patients were followed up four years later.[1] In the acute ulcer group, four had required further surgery, three had died from medical diseases after being free of indigestion for two to four years, and 10 had remained well and free of indigestion. In 13 out of 17 patients the decision to practise simple suture had, I believe, been fully justified. This small series only underlines the results of much larger ones in which the results of simple suture of acute ulcers have been assessed.[2,3]

I feel, therefore, that Mr. Machayya is on very doubtful ground when he argues that definitive surgery is indicated for all perforated duodenal ulcers. Vagotomy is an operation with certain immediate and late complications, and these should not be bestowed on patients who do not need to suffer them.

There is a further important point. Emergency surgery is very largely practised in Great Britain by staff receiving their surgical training. If vagotomy and pyloroplasty is to become widely adopted, it means that this operation may well be performed by those who have not yet completed a thorough grounding in elective gastric surgery. This is not in the interests of patients. If definitive surgery is to be done, then it must be performed by experienced surgeons. As surgery is currently organized, these may well be consultants or senior registrars who already lose as much sleep as they can afford.

I remain a firm believer in definitive surgery for those patients with a perforated duodenal ulcer who have a long history of indigestion and are fit for the operation. They are always delighted when they learn that the operation was designed to prevent further trouble. But I believe careful judgement should be exercised in selecting these patients; this judgement must include an assessment of the experience of the surgeon. —I am, etc.,

PETER F. JONES.

Aberdeen.

REFERENCES

1 Jones, P. F., *Postgrad. med. J.*, 1960, **36**, 768.
2 Gilmour, J., *Lancet*, 1953, **1**, 870.
3 Noordijk, J. A., *Acta chir. neerl.*, 1953, **5**, 262.

SIR,—Mr. M. S. Machayya has shown (19 October, p. 155) that truncal vagotomy and pyloroplasty can be carried out safely, and with good immediate results, in the management of perforated duodenal ulcer within the first six hours provided that the patient is not too old. He has not, however, shown that this operation is necessarily desirable.

He states that about 75% of those treated by simple suture will subsequently have further symptoms, and that most of these will require further definitive surgery. Professor A. W. Kay,[1] however, gives a figure of less than half requiring further operation. Most surgeons would probably accept a figure of 50%. A policy of indiscriminate vagotomy for all cases of perforated duodenal ulcer would thus mean an unnecessary denervation in about half the patients. This would be of little moment, provided that there was no increase in the immediate mortality, and that there were no undesirable side-effects of either vagotomy or pyloroplasty. Unfortunately, dumping, diarrhoea, and other disorders of intestinal, pancreatic, and biliary function do occur all too frequently. To produce crippling diarrhoea in a young man with an acute duodenal ulcer would be a disaster.

Some, at least, of the poor results of vagotomy are due to defects of the patient's personality. The experienced surgeon tries to exclude psychiatric and personality problems before recommending definitive surgery for ulcer, but in the patient with acute perforation a proper assessment of the patient's personality is obviously not possible. All of Mr. Machayya's patients were treated by truncal vagotomy, but an increasing body of surgical opinion favours the more sophisticated selective or gastric vagotomy, an operation which requires more time and more