

A CASE REPORT ON A 103 YEAR OLD PATIENT WITH PERFORATED PEPTIC ULCER

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SUMMARY

A 103 year old patient was admitted with pain in the right iliac fossa. There was no response to conservative treatment. Subsequent laparotomy showed the presence of a perforated ulcer in the pyloric region. The condition improved gradually after the surgical management.

INTRODUCTION

Children are not simply miniature adults, similarly the elderly show many modifications of patterns of disease as compared with younger adult patients. The non-characteristic clinical signs combined with the difficulties of history taking and physical examination in the elderly render accurate diagnosis more difficult. The delay in diagnosis and treatment with the presence of complicating diseases contribute to the high mortality in the age (Mckeown, 1965).

The following case report is to emphasize the diagnostic difficulty of perforated peptic ulcer in an extremely old patient.

CASE REPORT

A female patient, 103 years old, was admitted in May, 1980 with pain in the right iliac fossa for two days. The pain started in the epigastric region and later shifted to the right iliac fossa. She gave a history of anorexia with loss of body weight for the last few months. She had no bowel

movement for three days and claimed that it was associated with little intake of food. She had no history of epigastric pain or melaena. She did not take any herbs.

On examination, the patient was emaciated, pale, non-toxic and afebrile. The abdomen was soft. There was tenderness with slight rigidity in the right iliac fossa. Rebound tenderness was absent. Bowel sound was sluggish. Per rectal examination revealed slight tenderness on the right side.

Laboratory investigations showed that her haemoglobin was 10.6 gm/dl, white blood cell count was 2800/cmm with 75% polymorphs and 25% lymphocytes. Her urinary examination was normal. The chest the abdomen X-ray did not show the presence of subphrenic gas.

Under the diagnosis of chronic appendicitis, the patient was put on conservative treatment. After three days of observation there was increase of tenderness and rigidity in the right iliac fossa. However there was no rebound tenderness. Bowel sound was absent. The patient was afebrile. As the patient's condition was progressively deteriorating under conservative treatment, a laparotomy was finally performed. During operation, a 2 cm ulcer with surrounding induration was found in the pyloric region, anteriorly. The peritoneal cavity was full of inflammatory exudate. Biopsy and simple closure of the perforation were done. The postoperative course was uneventful.

Histopathologically, there were signs of inflammation with cicatricial fibrosis, there was no evidence of malignancy.

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DISCUSSION

Perforation is the second most frequent complication of peptic ulcer. The symptoms and signs attending these perforations in elderly patients are often different from the classical picture. The dramatic onset of severe pain with board-like abdominal rigidity frequently does not occur, the onset tends to be more insidious.

The mortality rate of perforation rises steeply with age. The rapidly destabilizing effect of a serious insult in a patient unable to tolerate major stress because of age-related infirmity is undoubtedly responsible for the high mortality. In addition, there is frequent inordinate delay in treatment because of a delay in recognizing the gravity of the patient's condition. Lack of overt symptomatology and absence of a prior history are the main reasons for failure to arrive at an immediate diagnosis. Symptoms are often poorly localized and signs of peritonitis may be minimal. The usually expected sign of rigidity is frequently lacking and, while tenderness is usually present, it may be unimpressive in relation to the patient's distress. The decompensating effects of other organ systems for example, congestive heart failure, may mask the primary abdominal events and divert attention (Felix *et al.*, 1972). Because of the lower tendency for the perforation to seal and together with decreased ability of an elderly patient to handle a major insult, it makes resort to non-surgical measures hazardous unless there is good evidence of immediate and sustained response.

The basic problem in management of perforated peptic ulcer is to eliminate the perforation. In

life threatening situations, simple closure of the ulcer usually achieves good results (Berne and Mikkelsen 1958), on the study of 206 patients with perforated ulcers by Hardy *et al.*, (1961), almost 21 percent of their patients were over 65 years of age. But this group accounted for 25 per cent of the deaths in the entire series. This study emphasizes the impression that early operation with simple closure is strongly to be preferred over non-operative conservative measures. The object of treatment in most perforations is to save the patient's life. Extended and even definitive therapy must often be passed over in the emergency situation.

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