General Surgery Cases

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Waitemata DHB
Greenlane Medical Specialists

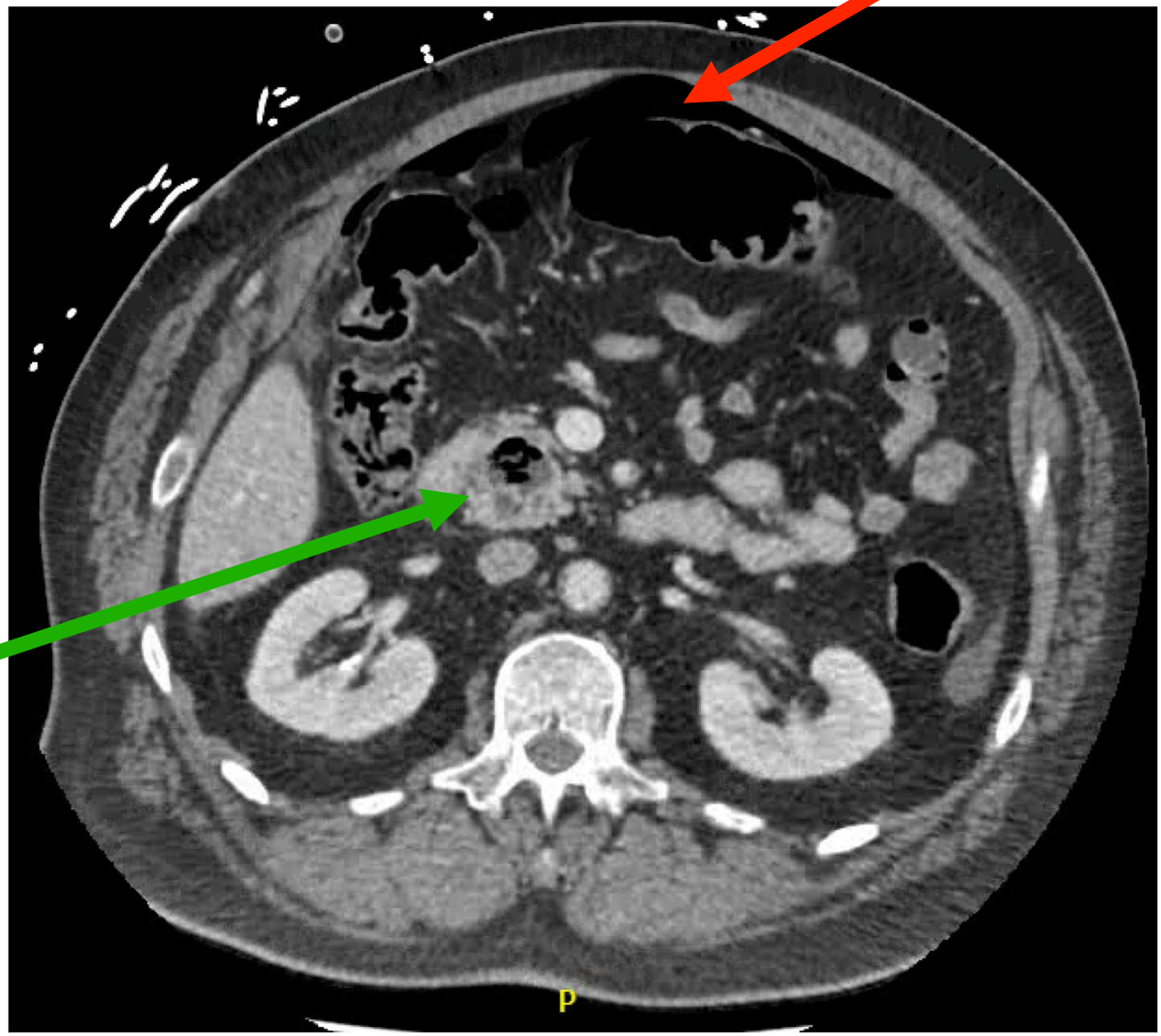
GLMS CME 11/8/25

Case 1

Case 1

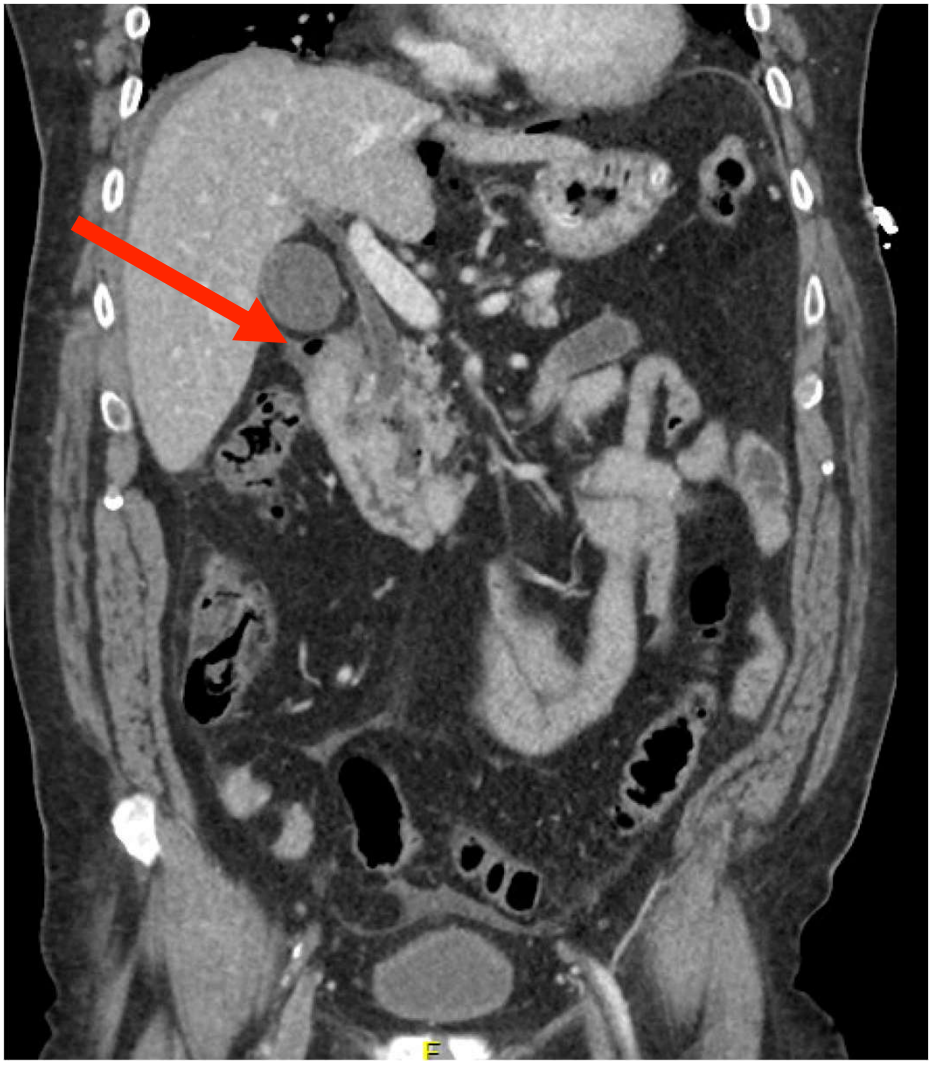
- 68y man
- Background of coronary artery disease, peripheral vascular disease (claudication), hypertension, T2DM, smoker
- Admitted with chest pain and troponin rise (NSTEMI). Angiogram showed severe diffuse triple vessel disease - waitlisted for inpatient CABG
- While inpatient developed severe abdo pain and lactate rise to 6
- Concern about ischaemic gut

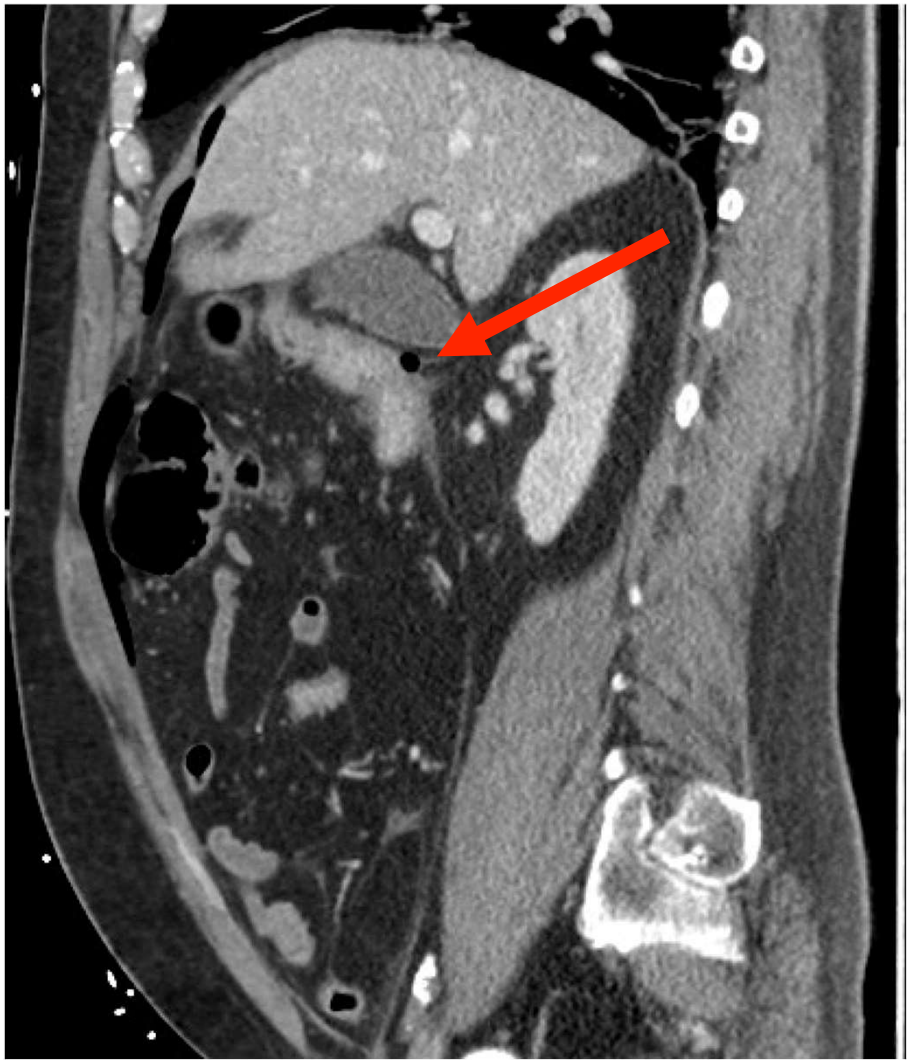
Free air



Duodenal diverticulum
(not perforated)

No bowel ischaemia



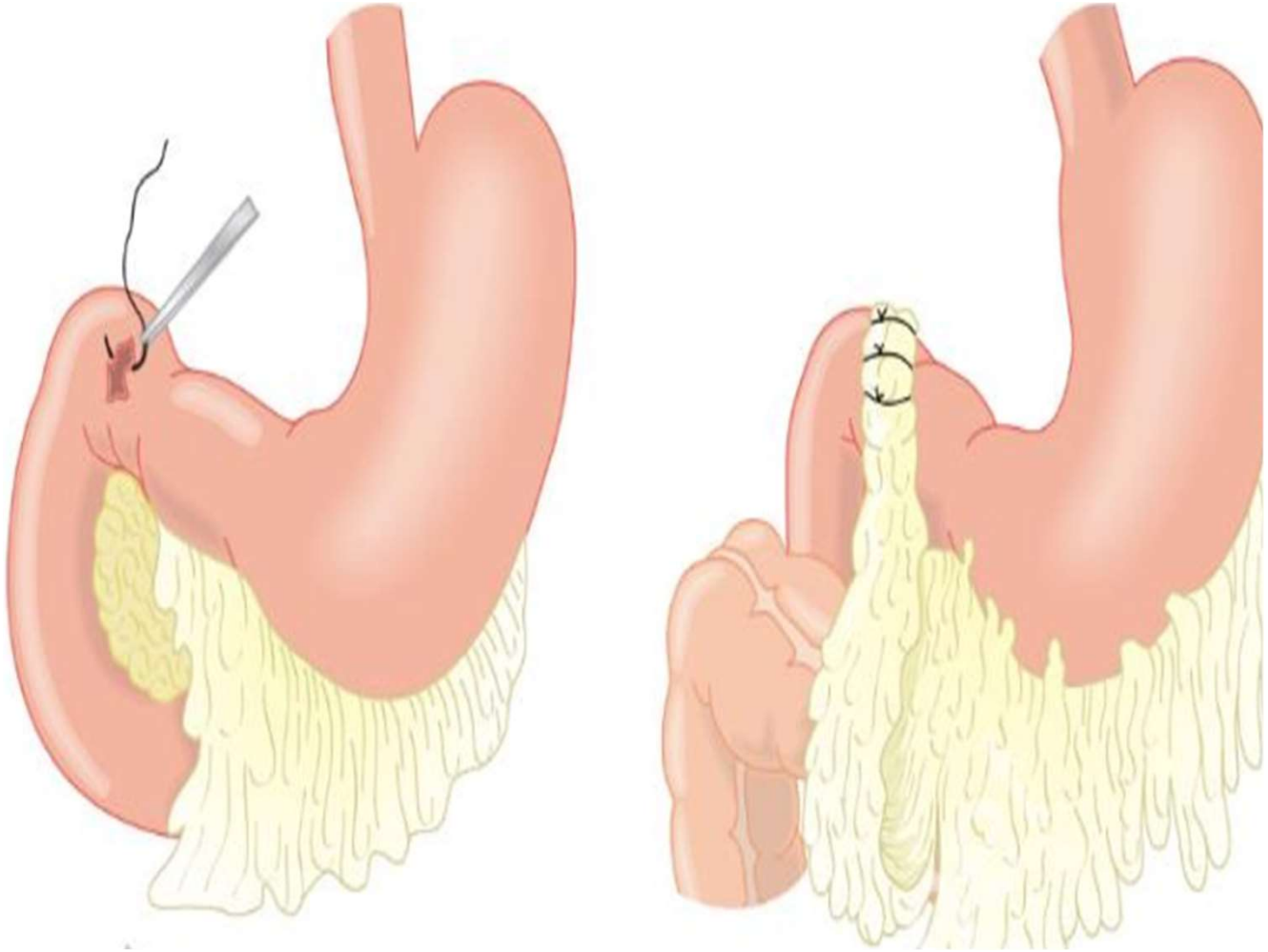


Suspected perforation of second part of duodenum

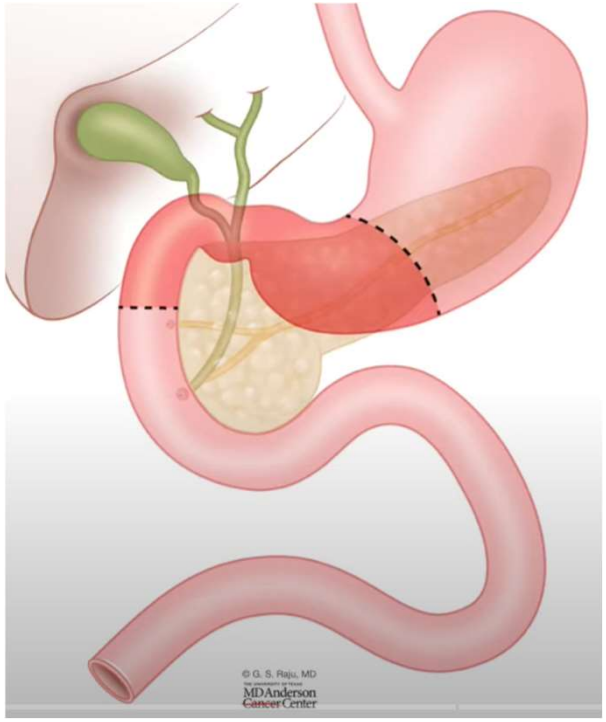
Case 1

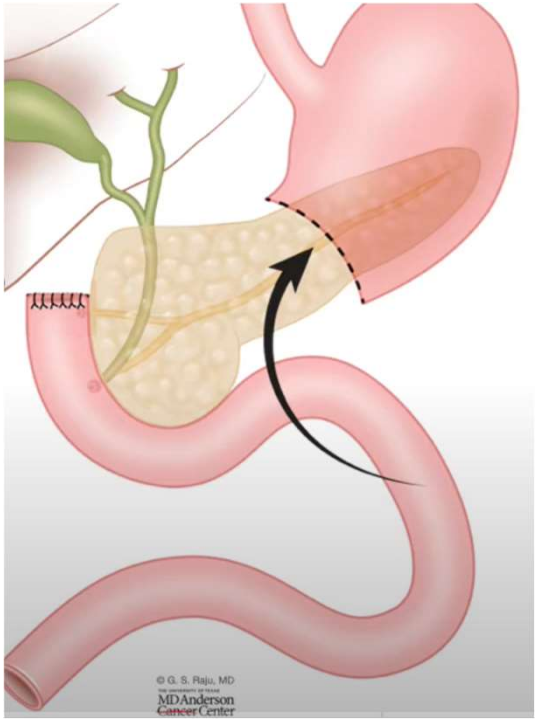
- Emergency laparotomy
- Pus and bile in abdomen
- 2cm perforated ulcer posterior duodenum 2nd part

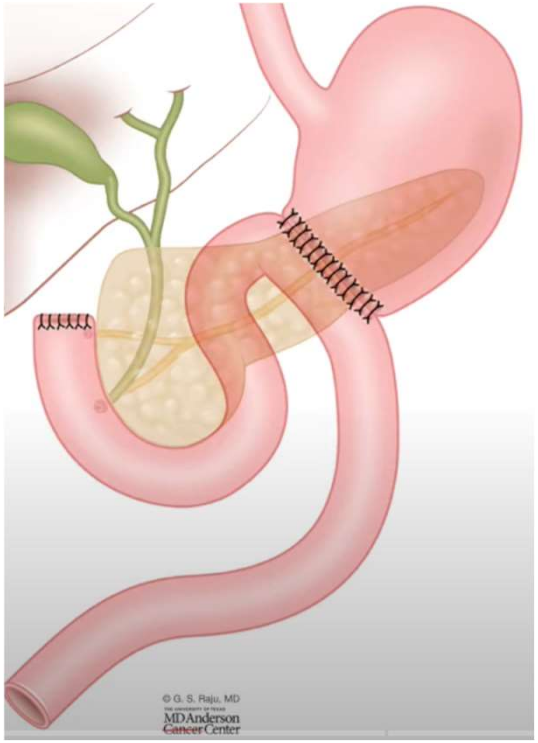
Omental Patch



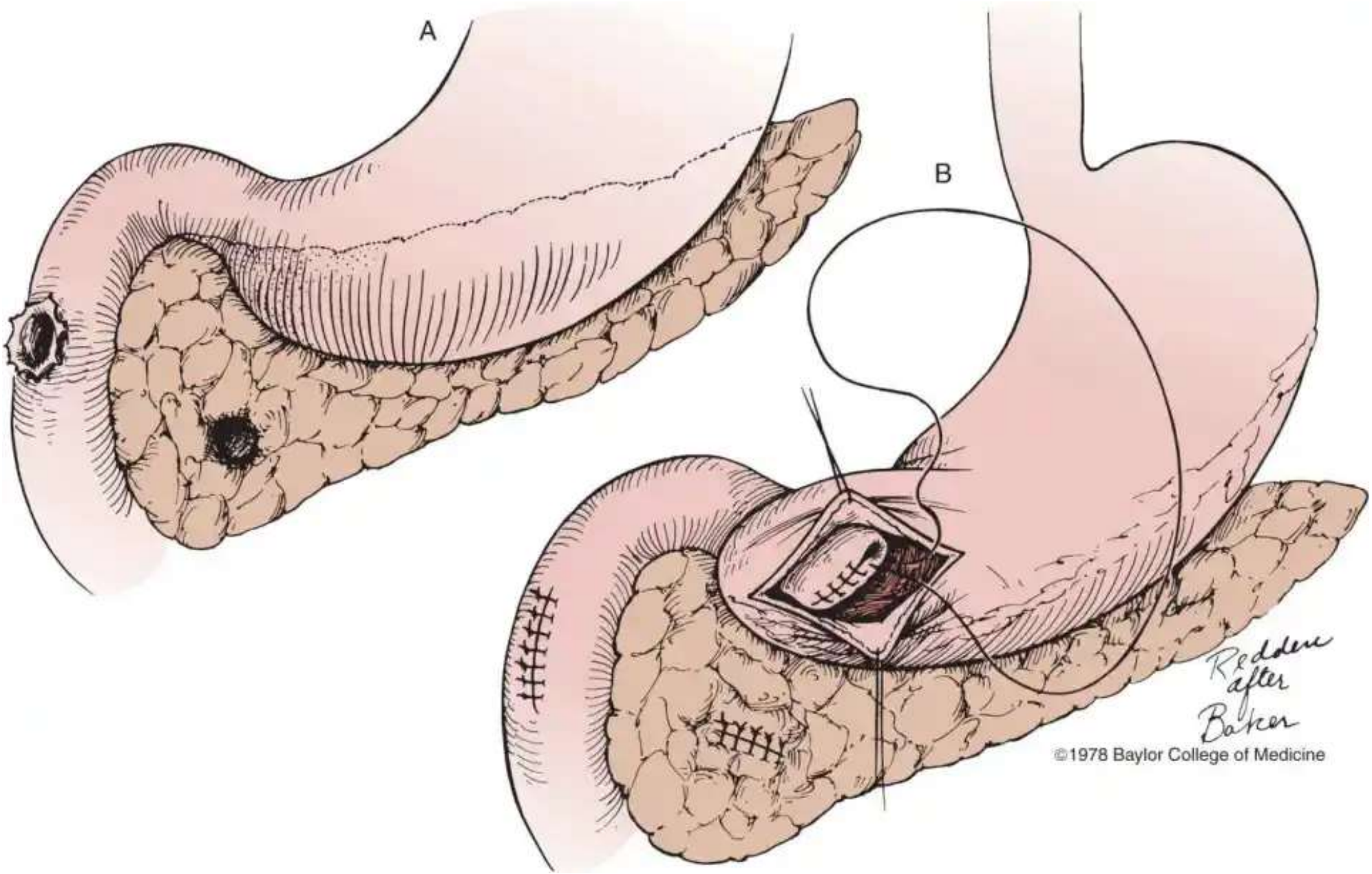
Segmental resection



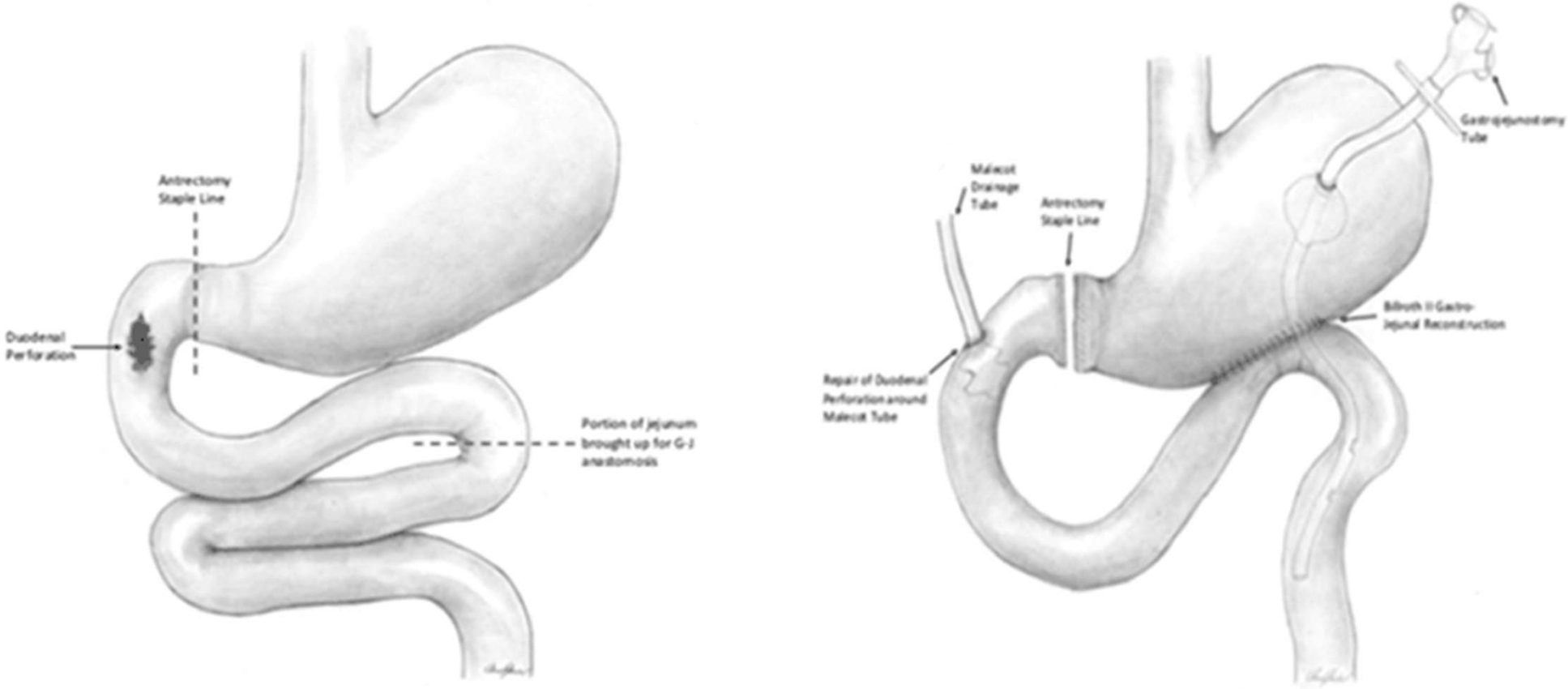




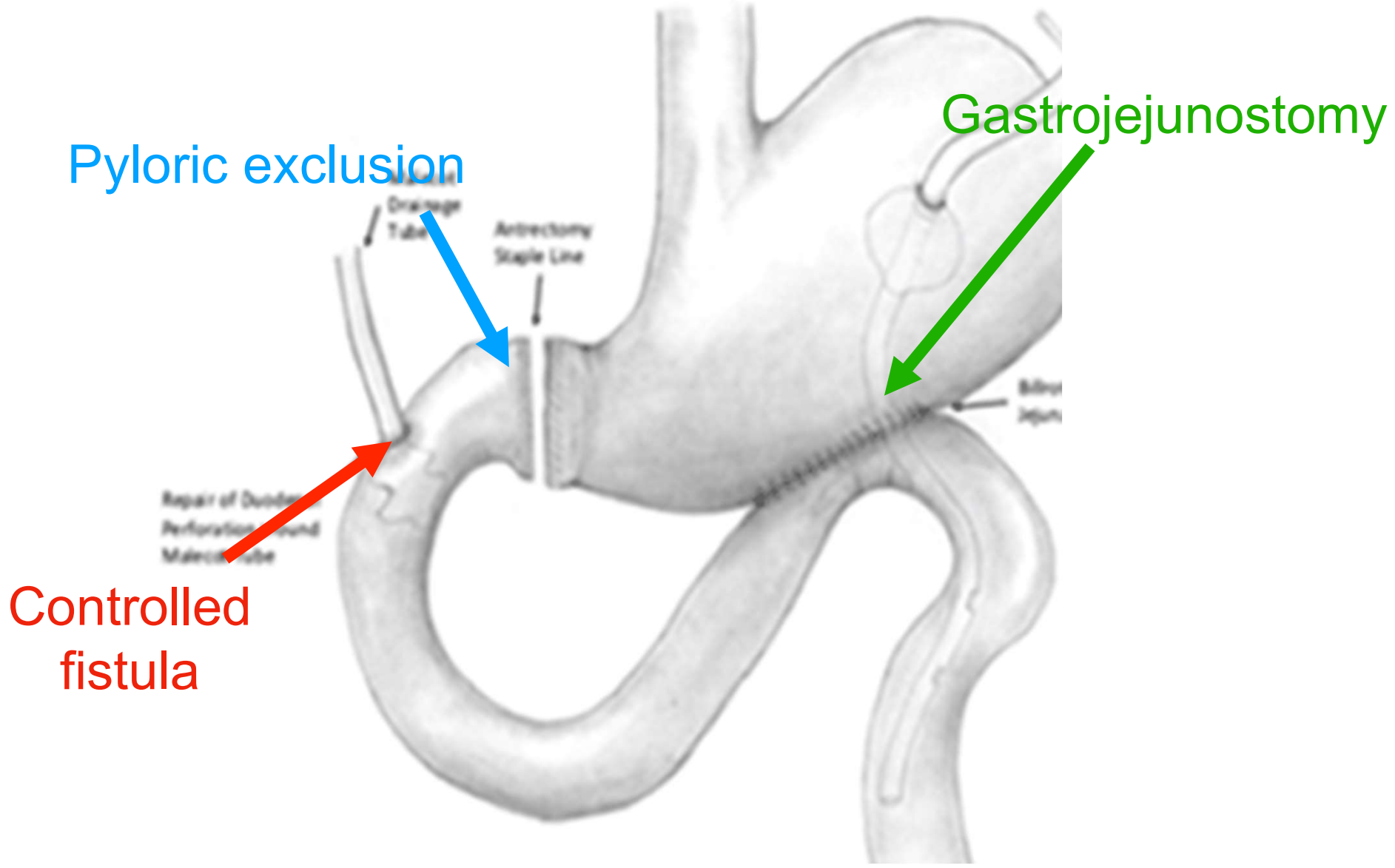
Pyloric exclusion

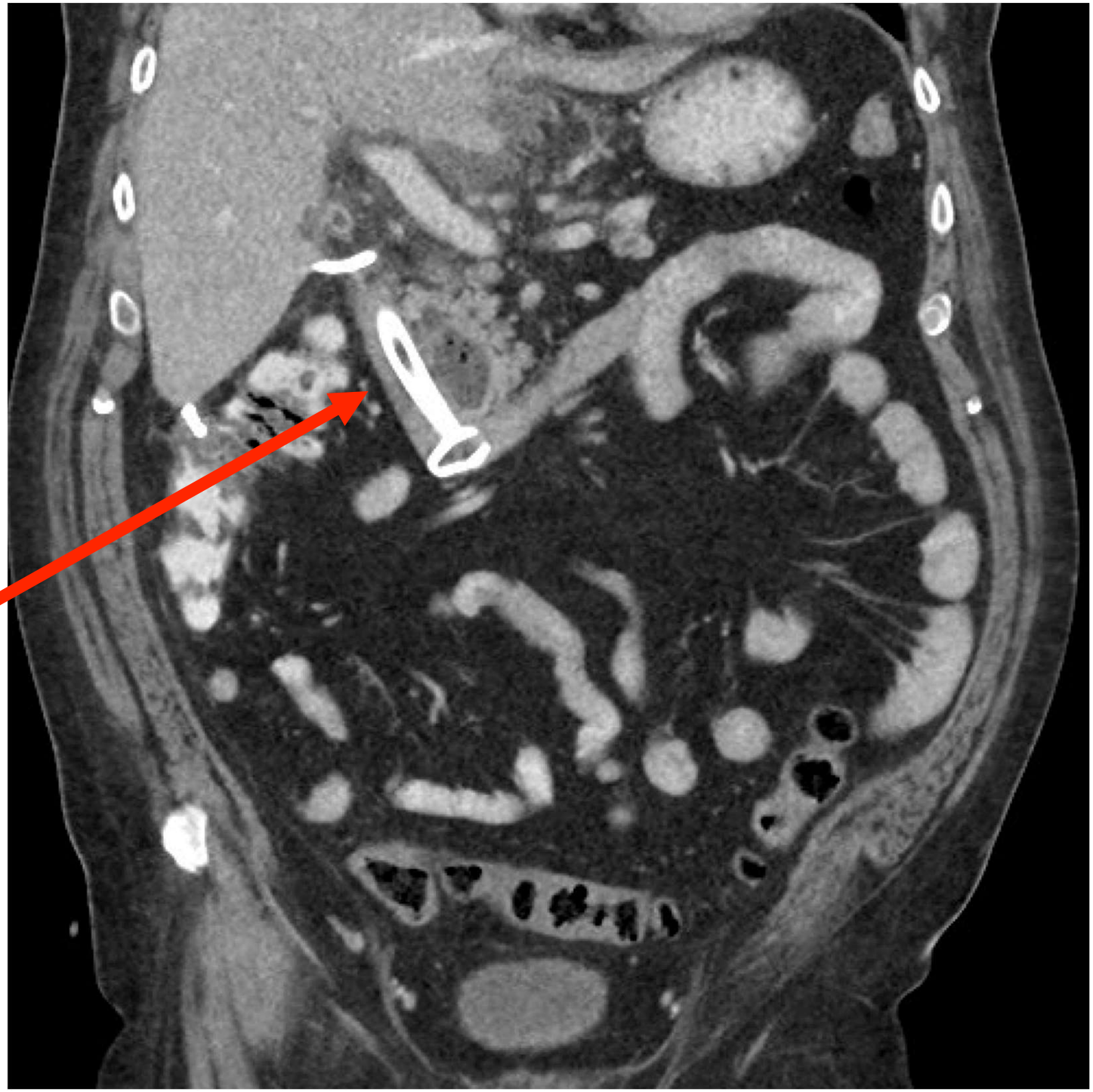


Controlled fistula with pyloric exclusion



Controlled fistula with pyloric exclusion




Drain sits within duodenum

Case 1

- Uncomplicated recovery. Discharged 3 weeks post-op with duodenal drain (spigotted) and peritoneal drain (to catch any leak)
- At 4 weeks he was still leaking 200mL/day of bile from peritoneal drain
- At 6 weeks the leak dried up but the duodenal drain was putting about 1L/day leading to some dehydration
- CT with drain contrast down duodenal drain showed no ongoing leak. Drain removed.
- Uncomplicated recovery subsequently.

Case 1

- Underwent successful CABG 6 months later
- 4 years later developed an incisional hernia, underwent an uncomplicated repair

Case 1

- Controlled fistula
  - Intubation of a large hole within a viscous that cannot be closed or resected
    - Encourages all viscous contents to leak into the drain and not into peritoneal cavity
  - Slow formation of a track around the drain by omentum, other organs, and fibrotic tissue
  - Allows removal of drain some weeks later
  - The track spontaneously closes
- Pyloric exclusion
  - Stapling or suturing off or resecting pylorus to stop stomach contents passing through duodenum
  - If sutured close, closed area recannulates after a few weeks