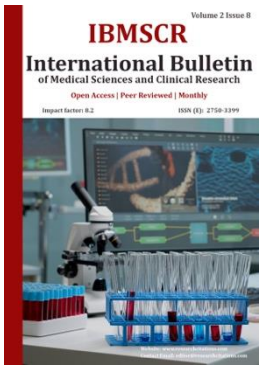

CHRONIC PRIMARY ULCERATIVE DUODENITIS WITH MULTIPLE EROSIONS OF THE DUODENAL BULB

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Annotation: Chronic duodenitis is a disease characterised by inflammatory, dystrophic and regenerative changes in the duodenal wall, predominantly affecting the mucosa. These changes are accompanied by structural reorganization of the glandular apparatus, the development of metaplasia and atrophy, and a prolonged course.

Keywords: Chronic duodenitis, gastritis and duodenitis,Endocrine ulcers, Complications, disease, mucosa, atrophy, metaplasia, multiple erosions, pain, symptoms, disorders, clinical forms, dumping syndrome, symptom, manifestation, diseases of the pancreas, perforation,penetration, malignisation, the bulb, ulcers.

Clinical forms:

Ulcer-like (the main symptom is late 'hunger' pain; the process, often erosive, is usually localised in the bulb of the duodenum);

Gastritis-like (dyspeptic disorders are predominant; often combined with chronic gastritis with secretory insufficiency);

Cholecysto- and pancreas-like (characteristic for papillitis, distal duodenitis; symptoms are caused by transient disturbance of bile outflow, pancreatic juice due to oedema and spasm of the sphincter of Oddi);

Nervous-vegetative (more frequent in women, characterised by vegetative and asthenoneurotic disturbances, manifestations of the dumping syndrome. It is based on a disorder of the endocrine function of the duodenum - duodenal hormonal insufficiency syndrome. It should be noted that other forms of CD have these symptoms, but they do not dominate in the clinic);

Mixed (combination of symptoms from different clinical forms);

Asymptomatic (more common in older people.

Classification of chronic duodenitis (Avdeev V.G., 1996)

Primary (isolated) duodenitis

Secondary (concomitant) duodenitis

Toxic (elimination) duodenitis

Peptic ulcer disease of the stomach and duodenum

- HP-associated (HP+)
- Non-HP-associated (HP-)

Б. Symptomatic gastroduodenal ulcers:

1). Stress ulcers:

a) in extensive burns (Curling ulcers)

b)in craniocerebral trauma, cerebral haemorrhage, neurosurgical operations (Cushing's ulcers)

c) Ulcers in other "stressful" situations: myocardial infarction, sepsis, serious wounds and oral surgery.
2). Drug ulcers: NSAID-related (induced), steroid, reserpine, etc.
3). Endocrine ulcers:
a) Zollinger-Ellison syndrome
b) Gastroduodenal ulcers in hypothyroidism
4). Gastroduodenal ulcers in some diseases of the internal organs
a) chronic non-specific lung diseases
b) rheumatism, hypertension and atherosclerosis
c) in liver diseases ("hepatogenic ulcers")
(d) diseases of the pancreas ("pancreatogenic ulcers")
(e) CKD
f) Rheumatoid arthritis
g) other diseases (diabetes mellitus, erythremia, carcinoid syndrome, Crohn's disease).
Localisation
1) Stomach (cardia, subcardiac region, antral and pyloric
antral and pyloric sections)
2). 12-intestine (bulb, post-bulbar section)
3). Combined ulcers
According to the number of ulcerative lesions:
- single
-multiple
By size (diameter) of ulcers
- small (up to 0.5 cm)
- medium (0.6-1.9 cm)
- Large (2-3 cm)
- Giant (> 3 cm)
Stages of the course of the disease:
- exacerbation
- scarring (endoscopic 'red', 'white' scars)
- remission (scar-ulcer deformity of the stomach and 12-peritoneum)

Complications:

- haemorrhage
- perforation
- penetration
- perigastritis or periduodenitis
- scar-ulcerous stenosis of the pylorus
- malignisation
- peptic ulcer disease

By the nature of the course of the disease:
- first detected
- mild (once in 2-3 years and less often)
- medium severity (1-2 times a year)
- severe course (2 times a year and more often)

Erosions are superficial defects that do not penetrate the muscular layer of the gastric and duodenal mucosa and heal without scarring.

Classification of erosions (V.D. Vodolagin, 1996)

Primary erosions

Secondary erosions (associated with the main disease)

Erosions as a manifestation of a malignant or systemic process in the gastric mucosa (malignant erosions in cancer, lymphoma, Crohn's disease, etc.).

Benign erosions:

4.1 Acute erosions

4.2 Chronic erosions Single and multiple erosions

4.3 Chronic erosive (lymphocytic) gastritis

4.4 Erosive haemorrhagic gastritis and duodenitis

CONCLUSION: If competent treatment is started in time, patients usually make a full recovery.

To reduce the risk of developing the disease, you need to pay attention to your diet:

eat 3-4 times a day, avoiding long periods of fasting

Limit or eliminate foods with trans fats, colourings and preservatives;

Eat a varied diet rich in fibre, vitamins, microelements and antioxidants, and increase your intake of fruit and vegetables;

Take into account individual food intolerances (the most common allergenic foods are milk, wheat, eggs, soya, nuts, fish and seafood).

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