Post - gastrectomy complications

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-Gastric resection operations are:(a) Partial (subtotal with continuty by (gastro jejunostomyBilroth II lor gastro-duedenostollY (Bilroth I) forcomplicated or intractble peptic ulcer or(b) Total gastrectomy for zollinger - ellison syndromeand for tumours of stomach •.post-Gastrectomy complications are1- Non specific: Infections, pulmonary and cardiaccomplicatj.ons, thrombotic complications, paralyticileus and burst abdomen.2- Speci~i-c 1-A- Due to altered anatomy (technical imperfections)which appear early • Thye include :1. Leakage from suture line especially after polya.With duedenal :!fistula, peritonitis , ileus andneed surgical drainage and tube feedings.2. Haemorrhage from anastomotic line due to imperfacthaemostasis or injury during operation ormissed lesion.It needs resutUT1.ng of bleedingvessels if conservative measures fail.- 1.37 -.3. Stomal obstruction with vomiting due to technicalerror or mechanical obstruction which needs correctionof cause after failure of conservativesuction, I.V. fluids and bethanecol drue_4. Injury to pancrease , bileduct and rarely acutepancreat it is •5. Decreased gastric capacity which deponds on theextent of resection and leads to early satiety,mal nutrition and anaemias and necessitate frequentsmall nutritive meals.6. Necrosis of gastric remnant • chronic atrophic gastritesand carcinoma on top of gastric remnant •B- Recurrent ulceration (5 - 10 %) due to both alteredanatomy (inadequate initial surgery) and alteredphysiology (gastrin) , it is treated iued LcaLy by antacidand cimet idine or surgical by vago tomy and resectionof antrum or remede anastomosis.c- Due to alter physiology and usually appearlater as :-1. Post-gastrectomy syndrome.(a) EQrly dumping (5-12 %) due to rapid emptyingof large amounts of hypertonic liquid to jejenumits distension and~blood volume) giving bothgastro-intestinal and vaso motor symptoms andoccur in any operation which destroy or by passthe pylorus and managed by diet low in sugars,high in fat and prote~ small and dry in semisittingposition. Severe dumping necessitateremedial surgery as conversion to bilroth I,jejunal inter position or tripple poch or rouxen-y anastomosis.(b) Late dumping (reactive hypoglycaemia) 1 - 6 %due to insulin hyper sensitivity which necess~terestriction of carbohydrate to 50gm Jday •(c) Bilious vomiting 10 - 15 %.2. Nutritional syndromes: Mainly due to small Capacitysyndrome , dumping and mal absorption offat and protein :Ex : weight loss 50 % , steatorrhea (50%) anaemiai- Iron deficiency 40 % •ii- Megaloblastic 10 %(~Vit.B12 ~Polic acid), grossmal absorption 1 %), diarrhoea 5 %D- Q!~~!_Q2~21£s~!£2E~_~1. Somepsychatric symptomsand alcoholism2. Increase incidence of gall stones.3. Reactiviation of pulmorary T.B.4. otoseomalacia (Ca and Vit.D) and osteoporosis withpatho logica 1 fracture of bone.N.B. :1- The

higher the resection of the stomach the greaterthe risk of post-gastrectomy complications and thegreater protection against recurrent ulceration.2- Averge mortality after gastrectomy is 2 %. Post gastriccomplications occur in 20 % of patients with varyingdegree and is disabling in 1%of cases.3- Pure syznromes are rare. Majority are mixed clinicalpicture with domirant symptom.4- Follow up using investigations as (endoscopic monitoring• blood studies. radiological studies. testsof gastric secretions and emptying) is beneficial todetect and control such complications early andeffect ivly •5- Managment is directed to abolision or improvement ofsymptoms and remedial surgery if conservative treatment(diet, drugs and substitution of loss) has failedafter 1» - 2 years have elapsed.6- Highly selective vagotomy or truncal vagotomy withantrectomy has replaced partial gastrectomy for treatmentof most of peptic ulcer diseases nowadays.