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Discussion

Dr. Richard J. Field, Jr. (Centreville, Mississippi): In 1960, Dr. Hardy and Dr. Conn presented before this Association a group of 206 cases from the University of Mississippi. There were only eight primary gastric resections in their group. Thanks to the influence of Dr. Jordan, we last week, stimulated by his presentation, today, reviewed 198 cases from the University of Mississippi and find that we have become more aggressive. Our primary gastric resection rate for perforated ulcer is very similar to his, 23%.

I have this question for Dr. Jordan: Would he consider the morbidity of a pyloroplasty and vagotomy minimal enough, and knowing that we have had no problem with inflammation of the mediastinum from a vagotomy—would he consider going ahead with a vagotomy and pyloroplasty even in the older, and poorer risk cases, striving for a definitive procedure, primarily?

Our studies in 198 cases since Dr. Hardy and Dr. Conn's report revealed that 32 of these people had to have more definitive surgery after a Graham closure. There were 162 Graham closures in this group. We're wondering—and are beginning to turn this way in our own thinking—should we go ahead with a vagotomy and pyloroplasty, and save these people another procedure.

President Hardy: Dr. Jordan, in closing would you comment on the incidence of concurrent hemorrhage in these patients with perforated duodenal ulcer? We were surprised, some years ago, to find how many patients presented with both hemorrhage and perforation. We had usually taught that the posterior ulcers bled more often; and that the anterior ulcers perforated more often but did not bleed as often as the posterior ulcers. Do you have any data on that?

Dr. George L. Jordan, Jr. (Closing discussion): In answer to Dr. Field's question about vagotomy and pyloroplasty, the 12 patients that we indicated who had other procedures did have vagotomy and pyloroplasty, or vagotomy and gastrojejunostomy—the operating surgeon thinking, perhaps, that this was a lesser procedure. If one compares mortality rates, however, you find that it is not. Therefore, I personally perform a simple closure, or I will do what I consider the best operation for the prevention of recurrent ulcer; namely, vagotomy and gastric resection. As you know, I have never been enthusiastic about vagotomy and pyloroplasty, and my interest has waned as the years have gone by.

In answer to Dr. Hardy's question about hemorrhage, we do have a number of patients who have had associated hemorrhage. It has been only a small per cent, however, and thus it has not accounted for a large number of patients.