8. DIAGNOSIS AND TREATMENT OF ISOLATED DUODENAL INJURIES

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Introduction. The low incidence of isolated duodenal trauma results from its anatomic retroperitoneal location. When establishing the diagnosis of isolated duodenal trauma, investigative imaging methods have the highest priority.

Aim of study. The identification of diagnostic and treatment methods in isolated duodenal trauma.

Methods and materials. This is a retrospective study that includes 21 patients with isolated duodenal trauma, hospitalized in the IMU. The group included a distribution of 17 men and 4 women, between the ages of 18-70 years.

Results. The applied diagnostic methods were abdominal radiography (n=11),chest x-ray (n=5), USG (n=14), CT (n=5), laparocentesis (n=1), laparoscopy (n=4), FEGDS (n=2). Indirect signs of isolated duodenal injury were hemoperitoneum (9,5%), pneumoperitoneum (19,1%), retropneumoperitoneum (14,3%), retroperitoneal hematoma (4,8%), obvious duodenal injury (4,8%), diffuse peritonitis (19,1%), aerocoly (9,5%), liquid in BO (38,1%), postbulbar ulcer (4,8%). Hemoperitoneum (19,1%), retroperitoneal hematoma (23,8%), retroperitoneal phlegmon (28,6%), diffuse peritonitis (71,4%) were intraoperatively established. The detected duodenal lesions were located on the anterior wall (52,4%), posterior wall (33,3%), as well as their association (14,3%).%). The frequency of traumatized duodenal segments was: D1- 33,3%, D2-33,3%, D3-23,8%, D4-14,3%. The degrees of duodenal injury according to the AAST classification were the following: 1st group - 1 (4,76%), 2nd - 11 (52,38%), 3rd - 6 (28,57%), 4th - 3 (14,28%).The surgical treatment was carried out depending on the location, the damage degree and the hemodynamics of the patient. First patient had the duodenal deserosis sutured (4,76%); six patients in the second group (28,57%) dealt with duodenorrhaphy and exclusion of the pylorus [n=1(4,76%)], pyloroduodenoplasty [n=2(9,52%)], and the evacuation retroperitoneal hematoma [n=2(9,52%)]. Four third degree patients (19,04%) had the following performed: duodenorrhaphy with gastric resections; excluding the pylorus Șalimov procedure; Konishi gastric transposition, and duodenal pyloroplasty by Miculici [n=2 (9,52%)]. Severe degrees of injury (IV-V) requested following techniques: duodenorrhaphy [n=2(9,52%)] with GEA Von-Hacker and Jejunostomy Witzel; Konishi technique of exclusion of duodenum after with retrocolic GEA, and evacuation of retroperitoneal hematoma [n=1(4,76%)].

Conclusion. Isolated duodenal trauma presents an atypical clinical picture, with major difficulties in establishing the diagnosis. The applied investigation methods identified the presence of indirect signs of isolated duodenal injury.