Gastric and Duodenal Ulcers

Entity	Clinical Features	Pathologic Features	Treatment
H. pylori	Most common cause	Gastritis more common in antrum Ulcers may be in duodenum	PPI and antibiotics (depending on risk of macrolide resistance)
Chemical-induced ulcers	NSAID, aspirin (incl. 81mg) use	Fundus and body No background gastritis	Discontinue (or significantly reduce) NSAID
Stress	Multiple comorbidities Risk factors: prior PUD, CNS trauma/surgery, sepsis, multiple trauma, liver/kidney failure, steroids Curling: after burns Cushing: after neurologic damage	No background gastritis Fundus, body, duodenum Abrupt erosions/ulcers with interstitial hemorrhage, reactive epithelial atypia Adjacent mucosa with acute hemorrhagic gastritis, diffuse mucosal hyperemia, edema	Supportive Prophylaxis
Dieulafoy lesion	Middle-aged and elderly men	Proximal stomach on lesser curvature (also distal esophagus, small and large bowel) Small defect with large, thick-walled artery in base	Therapeutic endoscopy Surgical ligation or resection
Acid hypersecretory (Zollinger-Ellison)	Idiopathic PUD, chronic diarrhea	First part of duodenum through jejunum Prominent gastric folds	PPI Surgery
Cameron	Hiatal hernia	Linear, benign	Therapeutic endoscopy to control bleeding Surgery

References

- Odze, R.D., Goldblum, J.R. *Surgical Pathology of the GI Tract, Liver, Biliary Tract and Pancreas.* 2015. Ch 10.
- Yeo, C.J. *Shackelford's Surgery of the Alimentary Tract.* 2018. Ch 59, 60.