INTRODUCTION:

OMental patching began in 1929 by Cellan Jones and in 1937 Dr. Graham of Toronto reported 51 cases of perforated peptic ulcer (both duodenal and antral ulcer) successfully treated with a free omental patch.[1,2] This technique has been in vogue for almost 80 years now. In the original description of the technique, the full-thickness bites were placed approximately 0.5 cm away from the edges of the perforation from one margin to the other.[3,4,5] A theoretical hazard with the full-thickness bites is passing the needle through the posterior duodenal wall.[2] Commonly, 3-4 sutures are placed perpendicularly between the edges of the perforation and are laid out on each side of the duodenum.[3,4,5] A patch of omentum is brought without tension and positioned over the perforation, and the sutures are successively tied from the superior to the inferior aspect across the omental patch to anchor the omental graft in place. An important feature of a sturdy repair is reliant on the tying technique.[3,4,5] The applied tension to the sutures should be strong enough to stabilize the omentum in place but loose enough to preserve the omental blood supply.[3,4,5] Strangulation of the omental patch due to increased tension on the knots is associated with a failure of the repair and continued postoperative leakage.[3,4,5] There are many modifications to the same that has been described. In this article we add yet another technique to the armamentarium of surgeons to tackle duodenal perforation.

METHOD:

In this yet to be known technique we have modified the Graham’s patch by placing a serosal stitch on the duodenum/antrum to the apex of the omental flap covering the peptic ulcer perforation, so as to seal the perforation near the apex and prevent its slippage while placing the standard sutures to fix the omental patch. This helps the surgeons in training to place sutures without having any assistant to hold the omentum continuously in place and prevents torsion of the flap. This we also believe reduced the leak from the corners at apex. (Fig 1)

For ease of students performing Graham’s patch another useful tip would be to use haemostats of different sizes can be used as stays for each sutures placed so that there is no cross over between the subsequent sutures placed when they are tied over the patch.

In our initial experience of 15 cases, no complication were noted and all our patients had an uneventful postoperative course till discharge. All residents who used this technique found it much easier to perform the surgery in comparison to the standard pedicled omental patch technique.

REFERENCES:


FIG 1: Pedicled omental patch placed on perforation site with apical stitch (marked)