

Research Article

Duodenum as Part of the Human Digestive System

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Abstract

Duodenum length approx. 30 cm is part of the human digestive system, and the first of the three parts of the small intestine into which the digestive juices of the liver and pancreas (PH 5 - 7.5), the stomach, and bile from the gall bladder are poured. The mucous layer contains digestive glands. In the intestinal villi are blood and lymph capillaries.

Keywords: Duodenum, Gi Tract, Diverticula, Injuries, Health.

1. Introduction

The second part of the duodenum shares a common blood supply with the head of the pancreas and dissection of the space between the two organs may cause duodenal ischemia [1]. Isolated duodenal wounds due to limit injury frequently display with inconspicuous clinical signs and the diagnosis may be delayed. CT with intravenous differentiate and within the suitable cases verbal differentiate remains the foundation of early conclusion in patients with unpretentious clinical signs. Postponed determination and treatment are related with a tall rate of extreme complications and mortality. Duodenal divider hematomas after limit injury analyzed with CT check may be securely overseen conservatively. Be that as it may, all duodenal hematomas analyzed at exploratory laparotomy ought to be investigated to run the show out an fundamental puncturing and maintain a strategic distance from drawn out postoperative recuperation due to obstacle.

Duodenum

The duodenum, especially its moment and third parts, can be harmed with overzealous preparation of the hepatic flexure and undue care if the duodenum isn't carefully liberated from the mesentery of the colon [2]. The duodenum ought to be clearly distinguished, confined and reviewed for halfway or full thickness seromuscular tears and holes which are effectively repaired in a standard manner. With expansive surrenders more often than not as portion of a essential excisional method, the duodenum is assembled along its horizontal and back borders as distant as its average connection to the pancreas to permit a two-layer tension-free repair, a repair around a T-tube or Foley catheter to make a controlled fistula, or a Roux en Y circle (end to side) anastomosis to the duodenal imperfection. Damage at the pancreatic border of the duodenum or inclusion of the pancreas requires the skill of a pancreatic specialist as pancreatico-duodenectomy can be fundamental.

A missed harm show with peritonitis, which could be a surgical crisis, or as a fistula through a drainage tube that can be overseen conservatively, given the persistent isn't septic, the yield is moo and there's no intra-abdominal collection on a CT-scan. Be that as it may, early surgical intercession is as a rule supported particularly on the off chance that a differentiate consider illustrates a expansive duodenal leak. The choice of surgical strategies is comparable to elective repair in spite of the fact that the estimate of the deformity, tying and friability of the tissues by encompassing irritation ought to decide the most secure alternative.

The duodenum includes a wealthy vascular arrange provided by branches of the celiac trunk and prevalent mesenteric course [3]. The most sources of blood are prevalent and second rate pancreaticoduodenal supply routes, which are branches of the gastroduodenal supply route (branch of the common hepatic artery) and prevalent mesenteric course. The upper fragment of the duodenum is provided from a few other sources counting the supraduodenal artery (department of the gastroduodenal course), right gastric artery, and gastro-omental artery. The prepyloric vein found on the front duodenal divider is clinically important, passing beneath the pylorus. and serving as a direct to the gastroduodenal intersection and pyloric ostium for the specialist. In its distal section, the duodenum is provided by the front and back pancreaticoduodenal arteries as branches of the predominant mesenteric course. The finishing branches of duodenal supply routes shape anastomoses between the celiac trunk and the predominant mesenteric course.

Jejunum and ileum are provided with blood through the prevalent mesenteric course and its 15-18 intestinal branches that frame anastomoses known as blood vessel arcades. They end in terminal branches known as vasa recta, in this way empowering double blood supply. Vasa recta enter into muscularis mucosae to make blood vessel plexus with sub-

mucosa. The predominant mesenteric artery also supplies the proximal portion of the colon, though the second rate mesenteric artery supplies the distal colon.

Venous blood from the duodenum is depleted by the pancreaticoduodenal vein, which purges into the prevalent mesenteric vein and common hepatic vein. The stomach locale is depleted by the splenic vein, and the little digestive tract by the predominant mesenteric vein, whereas the second rate mesenteric vein is dependable for venous blood draining from the colon. Venous plexus within the zone is went with by blood vessel plexus, and all veins purge straightforwardly or by implication into the entrance vein basin. Lymphatic drainage of the stomach related tube as a rule follows blood supply and incorporates various lymph hubs. The whole little digestive system is luxuriously supplied with lymphatic vessels. The efferent intestinal lymphatic vessels purge into the cisterna chyli, and after that join systemic lymphatic circulation through thoracic conduit.

Trauma

A larger part of duodenal wounds are due to entering trauma, more often than not gunfire wounds [1]. Duodenal harm taking after limit trauma is uncommon due to its ensured area profound inside the retroperitoneum. In a National Trauma Data Bank (NTDB) think about of 388,137 patients with blunt stomach trauma, the in general frequency of duodenal injury was 1.0% and disconnected duodenal injury was 0.6%.

Blunt duodenal trauma ordinarily happens after coordinate trauma to the abdomen, coming about in compression of the duodenum against the vertebral column or after deceleration wounds in high-speed mishaps. In stomach trauma due to a directing wheel or handlebar damage affecting the front abdomen, an related flexion/distraction break of L1-L2 vertebrae (Chance break) may be seen. In children, limit trauma driving to duodenal injury is more common, due to the more even costal edge and flexible stomach musculature, advertising less assurance from tall affect powers to the stomach divider.

Duodenal injuries are evaluated by the American Association of the Surgery of Trauma. Grades I or II are considered as minor injuries, Grade III as moderate, and Grades IV or V as severe wounds. More than 80% of patients with duodenal trauma have either Grades I, II, or III injuries. Within the military setting with higher speed bullet or impact wounds, injury casualties involvement higher review trauma with almost 40% having Grades IV or V duodenal injuries.

Gastroscopy

Most patients with typical comes about from gastroscopy, duodenal biopsies and colonic examinations can be released to their GP (general practitioner) [4]. We inquire the GP to safeguarded that patients total a 3-month course of press treatment once the hemoglobin has returned to ordinary and to check the complete blood number at 3-monthly interims for 1 year after wrapping up press treatment. In case the iron deficiency repeats at that point we inquire for patients to be restarted on press and alluded for advance appraisal.

In patients matured between 40 and 60 a long time with typical comes about from gastroscopy, duodenal biopsies and colonoscopy, barium examination of the small bowel is performed to search for little bowel tumors, which seldom happen in this age group, and Crohn's disease. In older patients no further investigation is routinely performed.

Gastrointestinal Bleeding

The examination of obscure GI (gastrointestinal) bleeding is frequently a challenge to both radiologist and gastroenterologist, and near collaboration is required in the event that the determination is to be come to with the least of obtrusive tests [5].

Within the intense setting, if the location of blood loss is felt to be within the upper GI tract, at that point the primary examination is endoscopy to assess the esophagus, stomach and duodenum. In the event that this examination falls flat to uncover a source for the bleeding, such as ulceration or mucosal tear, at that point extra radiological thinks about will be required. Examinations that will offer assistance incorporate atomic pharmaceutical ponders or mesenteric angiography, but the choice will require near contact with the radiology office. In patients with proceeding GI bleeding, the examination of choice may be a mesenteric angiogram with specific catheterization of the celiac, prevalent mesenteric and second rate mesenteric vessels. This will distinguish a bleeding location in around 90% of patients in case the rate of blood misfortune is more prominent than 0.5 ml min⁻¹. In more incessant blood misfortune, atomic pharmaceutical studies with technetiumlabeled erythrocytes have an set up put in diagnosis. Once a bleeding location has been distinguished, an angiogram is regularly required to localize more absolutely the bleeding point. Every so often a tumor redden will uncover the diagnosis, indeed when no dynamic bleeding is illustrated. On the off chance that this comes up short to identify an anomaly, thought ought to be given to assessing the little bowel with a little bowel enteroclysis.

In patients with intense bleeding from the lower GI tract, colonoscopy can be amazingly useful but can be exceptionally troublesome because the colon is ill-equipped, and other ponders such as angiography or atomic medication can be accommodating.

In patients with accepted unremitting GI blood misfortune who display with IDA (iron deficiency anemia), the complete of the GI tract has to be inspected. Patients ought to have an upper GI endoscopy to look at the esophagus, stomach and duodenum. These patients ought to have biopsies of the moment portion of the duodenum so that a determination of celiac illness can be made or prohibited. Indeed in the event that a injury is recognized at upper GI endoscopy, the colon still requires assessment. In fit patients, most centers would offer either a colonoscopy or a combined adaptable sigmoidoscopy and double contrast barium enema. The choice between these tests depends incredibly on neighborhood arrangement. Colonoscopy permits the appraisal of better mucosal detail than a barium enema and can moreover treat a assortment of conditions amid the same visit. The barium

enema is, be that as it may, a measurably more secure test, which features a higher chance of enough looking at the full colon. The utilize of carbon dioxide as the insufflating gas permits a high-quality barium enema to be performed on the same day as a adaptable sigmoidoscopy due to the fast clearance of gas. Usually a noteworthy advantage in that it decreases the number of visits that patients have to be make to the healing center. Progressively a virtual colonoscopy strategy utilizing CT (computed tomography) is utilized as an elective. In this test, the understanding has full bowel planning and rectal gas followed by abdominal CT in both the inclined and recumbent positions. The colon can at that point be surveyed for mucosal injuries. This test has the advantage of appearing a extend of extraluminal illness that will be clinically critical. In patients who are exceptionally stationary, a CT scan with negligible persistent planning can be utilized. The understanding is given verbal differentiate to drink the night some time recently the examination in expansion to the standard planning. CT will at that point illustrate most noteworthy colonic pathology with negligible distress for the persistent.

In patients with suspected GI bleeding in whom the conclusion still remains hazy, little bowel enteroclysis is shown. This will distinguish little bowel tumors as nodular overlay thickening or as a central stricture and will also exclude CD (Crohn's disease). In the event that this test is additionally negative, at that point a pertechnetate filter to seek for heterotopic gastric mucosa inside a Meckel's diverticulum may once in a while be helpful.

Injuries

Duodenal injuries may not be apparent from the beginning physical examination or x-ray studies [6]. Abdominal films will uncover retroperitoneal gas inside 6 hours after damage in most patients. CT performed with a differentiate operator will as often as possible identify the location of aperture. Most duodenal wounds can be treated with horizontal repair. A few may require resection with end-to-end anastomosis. Sometimes, pancreaticoduodenectomy or duodenal redirection with gastrojejunostomy and pyloric closure is required to oversee a serious damage. A duodenostomy tube is valuable in decompressing the duodenum and can be utilized to control a fistula caused by an injury. Jejunal or omental patches may too help in avoiding a suture line spill. A distal jejunostomy bolstering tube is supportive within the long-term recuperation from these injuries.

Duodenal hematomas causing high-grade obstruction as a rule resolve with nonoperative administration. Patients may require add up to parenteral nourishment. In a few cases, a small-bore enteral nourishing tube can be passed past the zone of hindrance utilizing interventional radiology methods. Huge hematomas may require agent clearing, especially when the hindrance endures for more than 10-14 days and a diligent hematoma is seen on CT scan.

Most little bowel injuries can be treated with a two-layer sutured closure, in spite of the fact that mesenteric wounds driving to devascularized portions of little bowel will require

resection. The basic guideline is to protect as much little bowel as conceivable.

For injuries to the colon, the past approach has been to occupy the fecal stream or exteriorize the damage. Be that as it may, more recent studies have appeared the next complication rate with colostomy arrangement than with essential repair. Wounds ought to be considered for essential repair in case the blood supply isn't compromised. Essential repair is more likely to be related with complications in patients with continuous stun, in those requiring different transfusions, if more than 6 hours elapse between damage and operation, or in case there's net defilement or peritonitis. Small, clean rectal injuries may be closed fundamentally in the event that conditions are favorable. The treatment of bigger rectal wounds including pelvic break ought to incorporate proximal redirection. Addition of presacral channels is discretionary. In this last mentioned case, coordinate repair of the rectal damage isn't required but ought to be performed in the event that it can be promptly uncovered. Water system of the distal stump ought to be performed in most cases unless it would further contaminate the pelvic space.

Duodenal Stump Dehiscence

Duodenal stump suture/staple line dehiscence may be a disastrous complication with an frequency of 1.1% and a mortality rate of 0.6% [7]. This complication happens most commonly after new surgery for a duodenal ulcer or for a dying gastric ulcer with or without harm. Its frequency after arranged resection for gastric cancer is uncommon. Within the lion's share of cases, the spill is due to a specialized mistake and disappointment of the suture or staple line. Other components may contribute to the breakdown of the duodenal stump, such as the hindrance of the afferent circle, pancreatitis, and irritation of the duodenum at the time of surgery. Patients ordinarily display amid the primary week after surgery with epigastric torment, fever, tachycardia, and a disintegration within the patient's condition.

Complications of duodenal stump dehiscence incorporate peritonitis and sepsis, pancreatitis, fistula arrangement, and cancer arrangement. Wide drainage of an aroused duodenal stump with a duodenostomy tube for decompression may anticipate suture line dehiscence or help in making a controlled fistula within the nearness of a spill. Administration of a stump dehiscence may warrant reexploration with water system of the peritoneal depression and the arrangement of channels within the retroperitoneum, but the directing guideline to take after in these cases is to satisfactorily deplete the region, or maybe than endeavoring to repair the kindled duodenum. Near consideration must be paid to liquid and electrolyte administration, TPN ought to be managed, or the understanding may be bolstered enterally on the off chance that a distal bolstering tube is set. Closure ought to happen in two to three weeks.

Duodenal Fistula

Most duodenal fistulae start in other zones of infected bowel, ordinarily colon and every so often little bowel or ileocolonic anastomoses, but there may be inherent duodenal Crohn's

disease as the source of the fistula [8]. The side effects of duodenal fistulae incorporate loose bowels and weight misfortune, but they may be asymptomatic and once in a while can as it were be recognized upon surgical investigation. Duodenal fistulae or strictures may be complicated by numerous jejunal or jejunoileal strictures or other fistulae. These must all be managed with at the same time. On event, a duodenal fistula may be complicated by a coloduodenocutaneous component if it takes after past laparotomy. It is imperative to appreciate that duodenal fistulae may start within the little bowel or sigmoid colon in proximity to the transverse colonic mesentery, as the fistulae may pass through the mesentery into the duodenum. In case the fistula isn't recognized and repaired, postoperative intra-abdominal sore and or duodenocutaneous fistula may create.

Surgery for duodenal fistulae may be moderately simple if there's only a pinpoint opening which may be closed in two layers. By and large, be that as it may, these fistulae require progressed surgical procedure, as a result of the vicinity of the pancreaticoduodenal vessels, resection isn't an option. Although a laparoscopic approach is conceivable, duodenal fistulae require progressed laparoscopic method with intracorporeal sewing. Since of the profundity of the duodenum and the trouble of dismemberment, duodenal fistulae should generally be done as open strategies utilizing lit Britetrac retractors for satisfactory introduction. To constrain the length of the cut, the flexures can be mobilized laparoscopically in case one encompasses a coloduodenal fistula. After suitable partition from the duodenum and after that resection of the unhealthy colon or little bowel, one can start to address the duodenum itself. As with duodenal ulcer aperture, it is imperative when repairing a duodenal fistula that the edges be roused back to well-vascularized flexible tissues. A restricted wedge extraction in a transverse course is some of the time conceivable without compromising the lumen. Once this has been carried out, we continuously cover the repair with a jejunal fix, sutured circumferentially with interrupted #3-0 silk. If the lumen is limited, at that point a gastroenterostomy or Roux-en-Y duodenojejunostomy may be required.

Diverticula

Acquired diverticula are extra-luminal and are a reasonably common coincidental finding more often than not visualized either upon esophagogastroduodenoscopy (EGD), endoscopic retrograde cholangiopancreatography (ERCP), or by barium swallow and little bowel take after through [9]. Rates shift altogether within the writing depending on the diagnostic methodology utilized. Within the ERCP writing, rates up to 23% have been detailed, ordinarily expanding with progressing age.

In terms of area, these diverticula are generally located within 2 cm of the ampulla. This can be an zone of debilitating of the duodenal divider mucosa, particularly around the papilla of Vater, due to the setup and introduction of the smooth muscle fiber and the sphincter component of Oddi. On the off chance that the papilla is included or included in these diverticula, sphincter brokenness may lead to biliary dyskinesia, arrangement of biliary stones, cholangitis, and indeed

pancreatitis. Procured diverticula are too show within the third and fourth parcel of the duodenum with diminishing recurrence.

More often than not, these diverticula are asymptomatic. Side effects, when display, regularly are caused by either brokenness of the sphincter of Oddi or, when the diverticula are altogether expansive, by obstacle of the biliary and pancreatic channels due to outside compression. Repetitive scenes of pancreatitis possibly advancing into inveterate pancreatitis and arrangement of biliary stones have been detailed in patients with huge duodenal diverticula. Moreover, expansive diverticula can cause bacterial abundance coming about in malabsorption and iron deficiency. Diverticulitis with potential aperture and bleeding from duodenal diverticula has been detailed.

Determination is regularly gotten by EGD or ERCP. An upper GI with a little bowel take after through is additionally exceptionally supportive in localizing the diverticula and in characterizing the estimate of it. When a puncturing is suspected, CT filter of the abdomen with verbal and IV differentiate can precisely characterize the area of the diverticula and the degree of the provocative response to the diverticular aperture.

Surgical treatment of duodenal diverticula is complicated by critical horribleness and mortality, in this manner a prophylactic resection of an asymptomatic duodenal diverticulum isn't routinely suggested. Within the nearness of puncturing or bleeding, a generous Kocher move ought to be performed in arrange to distinguish the back angle of the duodenum. It is exceptionally vital at this organize of the method to have a clear thought of the relationship of the biliary and pancreatic channels with the ampulla in order to maintain a strategic distance from an harm that will be greatly troublesome to repair in this setting and area. On the off chance that the pancreatic and biliary structures are not included with the diverticulum, within the nonattendance of noteworthy retroperitoneal defilement, a essential extraction of the diverticulum is indicated. The coming about deformity ought to be closed in two layers utilizing absorbable suture for the internal layer and non-absorbable suture for the external layer. With a huge duodenal deformity, a serosal fix method employing a defunctionalized circle of jejunum could be a valuable elective. In any case, within the nearness of critical edema and defilement, essential closure around a T-tube with waste of the encompassing region may be the as it were arrangement. In extraordinary cases, duodenal diverticulization by gastrojejunostomy with a stapled closure of the pylorus may be essential. A huge diverticulum within the third or fourth portion of the duodenum requires mobilization of the distal duodenum with extraction and essential closure. In this range, the relationship with the biliary and pancreatic conduit isn't clearly as vital and thus, a more aggressive approach can be undertaken.

5. Conclusion

The duodenum is located in the right part of the abdominal cavity, and the head of the pancreas enters the hollow of its horseshoe. The mucosa of the duodenum contains digestive

glands and intestinal villi. The duodenum is the first of the three parts of the small intestine, followed by the jejunum and only then the true small intestine. In the duodenum, there are Bruner's glands that secrete alkaline mucus that neutralizes stomach acid.

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