



STOMACH ULCER, CAUSES OF THE DISEASE, COMPLICATIONS, MODERN AND TRADITIONAL TREATMENT APPROACHES.

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Abstract. Gastric and gastric ulcers are common gastroenterological diseases characterized by damage to the gastric mucosa. The main causes of the disease include *Helicobacter pylori* infection, chronic stress, poor diet, alcohol, and NSAID (non-steroidal anti-inflammatory drug) use. Symptoms of ulcers include stomach pain, discomfort, nausea, and vomiting. Treatment strategies include *H. pylori* eradication, proton pump inhibitors, antisecretory and antacid drugs, and dietary and lifestyle changes.

Keywords: *H. pylori*, stomach ulcer, hydrochloric acid, perforation, penetration, ulcer bleeding, stomach cancer.

Introduction. Comprehensive treatment reduces symptoms and prevents disease progression. Gastric ulcer can cause serious complications for many patients — the most dangerous of which are bleeding, perforation, gastric outlet obstruction, and the risk of malignancy. In recent years, a number of new approaches have emerged in diagnostics and therapy: *H. pylori* strategies have been updated, endoscopic hemostasis methods (including hemostatic powders) have become popular, and invasive radiological methods (transarterial embolization) are used as an effective “salvage” method in adverse cases. The following is an analysis of complications, their causes, and modern, evidence-based treatment principles.

Complications — what is encountered and mechanism Bleeding (acute upper GI bleeding). Bleeding due to peptic ulcer requires urgent treatment in patients and can be associated with a high 30-day mortality. Erosion of the ulcer artery and coagulation disorders are the main causes. Modern endoscopic hemostasis (clipping, thermal coagulation, injection) remains the standard.

Perforation. Peritonitis occurs when the ulcer wall is completely penetrated—this requires surgical intervention, and early surgery can be life-saving. Gastric ulcer perforation may be associated with tumor in some cases—therefore, it is important to exclude malignancy in patients with perforated gastric ulcers. Gastric outlet obstruction. A large or healing ulcer may narrow the pyloric or distal gastric canal, causing vomiting and regurgitation; endoscopic dilatation or stenting is sometimes necessary.

Chronic blood loss and anemia. Persistent microbleeding or repeated major bleeding leads to chronic anemia and functional impairment. Risk of malignancy. Gastric ulcers, if detected by persistent changes or biopsy, are unlikely to be malignant—especially if the ulcer is suspicious in nature.

Modern treatment approaches (current and new) 1. *H. pylori* eradication - prevention and relapse prevention Detection and treatment of *H. pylori* effectively protects against relapse of peptic ulcers; this aspect is reinforced by the Maastricht consensus (Maastricht VI - recommendations on the latest consensus). *H. pylori* eradication significantly reduces recurrence and prevents acute complications, especially in gastroduodenal ulcers.



2. Antisecretory therapy: PPIs and new drug classes Proton pump inhibitors (PPIs) are key to improving ulcer healing and reducing recurrence. More recently, potassium-competitive acid blockers (e.g., vonoprazan) provide faster and more robust pH control for some patients—but require skilled guidance on local staffing and protocols. (Source: general review and ongoing studies).

3. Endoscopic hemostasis and new technologies — Traditional methods: epinephrine injection, thermal coagulation, clipping. — New and widespread methods: hemostatic powders (TC-325 / Hemospray and similar) — provide rapid and effective initial hemostasis, especially in severe or difficult-to-control hemorrhages; in some series, it has been shown to be beneficial in reducing 30-day rebleeding. These powders are often used as a salvage method in cases that have not responded to standard endoscopic therapies.

4. Interventional radiology: transarterial embolization (TAE) When no endoscopic method can control bleeding or the patient is not suitable for surgery, TAE — gastroduodenal embolization — is an effective “salvage” technique. Recent analyses have shown a high technical success rate of TAE, but rebleeding and mortality may persist in some cases — patient selection and prompt coordination are important.

5. Surgical and critical care management Operative management is required in cases of perforation, extensive necrosis, or failure of endoscopic/radiointerventional methods. Perforation can be repaired laparoscopically or open, depending on age and physiologic status; malignancy should also be considered in cases of perforated gastric ulcer.

6. NSAID-induced ulcers — prevention and specific treatment If the patient is taking NSAIDs or aspirin, the drug is stopped whenever possible or replaced with a COX-2 selective; prophylactic PPI is recommended in high-risk cases. Misoprostol also has a gastroprotective effect, but side effects (and contraindications in pregnancy) should be taken into account. 5 new and scientifically significant findings (in brief)

H. pylori eradication significantly reduces the recurrence of peptic ulcers—the Maastricht VI consensus strongly supports this practice.

Hemostatic powder (TC-325 / Hemospray) provides high levels of immediate hemostasis as a first-line or salvage therapy and has been shown to reduce 30-day rebleeding.

Transarterial embolization (TAE) is an effective alternative after endoscopic failure, with a high technical success rate, but the risk of rebleeding and mortality depends on the patient's condition.

Endoscopic technologies are rapidly evolving—new endoscopic devices and novel endoscopic techniques (reliable literature 2024–2025) are changing management.

NSAID prophylaxis and PPI use: PPI prophylaxis is effective and recommended in high-risk patients; misoprostol remains important, but side effects are considered.

Natural treatment of the disease.

Gastric ulcer is one of the most common problems in the digestive system. The most common form of this disease is gastritis. Gastritis is an inflammatory process that occurs as a result of



external (exogenous) and internal (endogenous) factors, as well as their interaction. Conclusion Complications of gastric ulcers (bleeding, perforation, obstruction, etc.) are serious, and modern therapy — H. pylori eradication, effective antisecretory therapy, advanced endoscopic techniques (including hemostatic powders), and, when necessary, transarterial embolization or surgery — can improve patient outcomes. Individual assessment of each patient, risk factor reduction, and close collaboration with a team of qualified specialists are important.

Chamomile tincture: 1 tablespoon of dried chamomile is poured with 1 cup of boiling water, infused for 15 minutes. Drink 2-3 times a day. Flaxseed liquid: 1 teaspoon of flaxseed is boiled in 1 cup of water and drunk warm.

Peppermint tea: Drink it after meals to aid digestion. While medicinal plants are beneficial, in some cases they can cause allergic reactions or incompatibility with other medications. Therefore, it is recommended to start any phytotherapy after consulting a doctor. In addition, our elders did not call pomegranate the fruit of Paradise for nothing, because every part of it, from the fruit to the root, has healing properties. In medicine, preparations made from the root bark of pomegranate are used to expel tapeworms. A decoction of the fruit bark is useful in treating diseases such as diarrhea, bloody diarrhea, and dysentery. The blue hyacinth, which blooms from March to May and bears fruit from July to October, is also one of the medicinal plants widely used in folk medicine. It is mainly found in irrigated crops, especially among betel nuts.

Conclusion. Practical recommendations (for doctors and patients) Test for H. pylori and eradicate it immediately if detected. Seek emergency medical attention if symptoms of bleeding (abdominal pain, abdominal distension, sweating, dark stools, or bright red blood) develop; endoscopic evaluation and treatment are necessary. Discuss PPI prophylaxis in patients taking chronic NSAIDs; switch medications if possible. If standard endoscopic methods fail, consult with specialists in hemostatic powders or interventional radiology (TAE)

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