• Abdominal pain is a common complaint in pediatrics
• Gastric/duodenal (peptic) ulcers leading to perforation is rare and is often low on the healthcare providers' differential
• Delay in diagnosis of peptic ulcers may lead to complications and increased mortality

• Surgical intervention indicated as a result of indirect signs of bowel perforation, peritoneal signs, acute abdomen, bleeding or obstruction
• Surgical intervention:
  - Classic surgery: Vagotomy with pyloroplasty
  - Ulcer excision with Graham patch and simple suture
• Nursing care
  - Diet: Strict bowel rest, NG tube may be placed (consider no manipulation of NG tube)
  - Pain management: IV pain medications until transition to oral pain medications.
  - Medications:
    - IV antibiotics
    - Proton Pump Inhibitor
  - Proton Pump Inhibitor
  - Alternate therapies
• Nursing interventions: O2B and IV, child life

• PMH: Asthma and ADHD, otherwise healthy
• Symptoms: Diffuse tender abdominal pain, non bilious emesis
• Workup: CXR with pneumoperitoneum, VS on admission: BP 152/86 | Pulse 121 | Temp 37.4 °C (99.3 °F) | Resp 32
• Surgical Course:
  - Diagnostic laparoscopy converted to open exploratory laparotomy with Graham patch repair of perforated duodenal ulcer, appendectomy
• Post operative course: NPO with NG on TPN, IV antibiotics and Proton Pump Inhibitor, PCA for pain. UGI prior to initiation of diet with no evidence of leak. Transitioned to full oral diet.
• Presumed cause: Ulcer biopsy showed inflammation, negative for H. Pylori, ulcer likely related to stress
• Follow up: Completed treatment for H. Pylori. He tolerates a normal diet and has returned to track and weight lifting.

• PMH: Otherwise healthy male with newly diagnosed brain tumorPreviously treated with chemotherapy and radiation.
• Symptoms: Abdominal distention post operative from craniotomy
• Workup: Abdominal X-ray with pneumoperitoneum
• Radiography is important, free air or pneumoperitoneum seen in the majority of patients
• Current evidence suggests: diet does not necessarily predispose patients to peptic ulcer disease, there may be a genetic component, emotional stress alone unlikely to cause ulceration, smoking may lead to ulceration, and alcohol unlikely to cause ulceration

• Perforated peptic ulcer should be considered in the differential diagnosis for the patient that presents with acute abdominal pain with peritoneal signs for early identification and treatment.

REFERENCE