

BILIARY-ENTERIC ANASTOMOSIS IN BENIGN AND MALIGNANT HIGH BILE DUCT STRICTURE

**A THESIS SUBMITTED FOR PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR M.D. DEGREE
IN GENERAL SURGERY**

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بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

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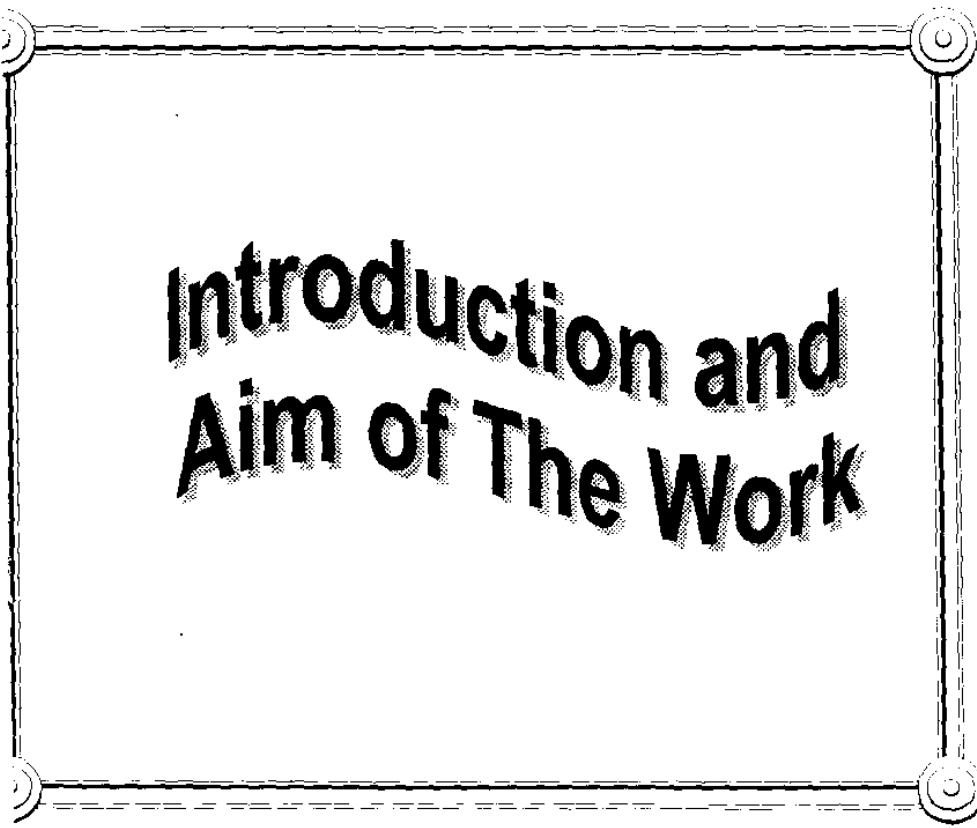
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Introduction and Aim of The Work

Introduction And Aim of The Work

Benign bile duct strictures represent one of the most difficult challenges that a biliary surgeon may face.

Before the advent of laparoscopic techniques, the incidence of major bile duct injury after cholecystectomy was thought to be fairly steady at about 1 in 300 - 500 procedure (0.2% - 0.3%) (**Garden, 1991**).

Although rates of bile duct injury reported vary considerably, in survey series after laparoscopic cholecystectomy, a bile duct injury rate of ten times that associated with open cholecystectomy was reported (**Deziel et al., 1993**).

Also malignant obstruction of the common hepatic duct can result from a number of causes, the most common cause is cholangiocarcinoma, but gallbladder carcinoma, primary or secondary liver tumors or certain gastric or pancreatic cancers can also be responsible (**Traynor et al., 1987**).

All of these pose a similar management problem which is the relief of obstructive jaundice.

Surgical decompression in obstructive jaundice caused by benign or malignant stricture is best obtained by biliary - enteric anastomosis mostly between common hepatic duct and jejunum.

When this approach is rendered difficult in high bile duct stricture or impossible because of tumor or dense fibrosis perhaps involving a variable length of hepatic ducts, adequate drainage can be obtained by biliary - enteric anastomosis to the left or right hepatic duct, or to the confluence of the hepatic ducts.

The aim of this work is to evaluate biliary - enteric anastomosis in relation to feasibility, operative complications and risk involved, advantages, disadvantages, limitations and effectiveness.

Review of Literature

