Port Site Complications Following Laparoscopic Cholecystectomy

Thesis

Submitted For Fulfillment of M.Sc. Degree
In
General Surgery

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2015

Acknowledgment

I would like to express my endless gratefulness to gracious ***God*** for helping me to achieve this work.

It was a great honor to accomplish this research under the supervision of ***Prof. Dr. Mustafa Abd El-Hameed Suliman***, Professor of General Surgery, Faculty of Medicine, Cairo University, for his guidance, support, valuable directions and continuous encouragement.

I wish to express my greatest appreciation for ***Prof. Dr. Tarek Ossama Hegazy***, Professor of General Surgery, Faculty of Medicine, Cairo University, for his great support and kind and careful assistance and valuable knowledge during this work.

Finally, I would like to thank all my professors, my seniors, my colleagues and my family especially my wife for helping me directly and indirectly to carry on this research.

Contents

List of Figures

List of Tables

List of Abbreviations

cm	**Centimeter**
mm	**Millimeter**
BMI	**Body Mass Index**
ASA score	**American Society of Anesthesiologists score**
SD	**Standard Deviation**
PSC	**Port Site complications**
PSI	**Port Site Infection**

Introduction

INTRODUCTION

Laparoscopic surgery, also known as minimal access surgery, is an approach to surgery whereby operations are performed with specialized instruments designed to be inserted through small incisions **(Assalia et al. 2006).**

There is no doubt that laparoscopic surgery has had marvellous positive impression on patients and the healthcare system worldwide. Patients prefer to have less pain, less morbidity and return to their daily activities as soon as possible **(Khan & Oonwala 2007).**

Therefore, the number of laparoscopic procedures done each year continues to rise substantially. There are over 2 million laparoscopic cases performed annually in the U.S **(Weiss et al. 2014).**

Despite the many technical advances in laparoscopic surgery equipment and the extensive experience of many surgeons, there is still a level of mortality and morbidity year from such an operation **(Assalia et al. 2006).**

The complications associated with port site vary in severity and in the time of presentation. It is well established that most of them are infections with skin flora bacteria. Other complications are haemorrhage, hernias and metastases. The latter three types are still much less than the former **(De et al. 2012).**

Our article did not discuss major complications of laparoscopic surgery like visceral or vascular injuries; our article discusses port site complications which represents less than 4% of the total overall complications.

Aim of the Work

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The aim of our study is to investigate the incidence, causes and natural history of port site complications during laparoscopic cholecystectomy along two years retrospectively in Police Hospital-Nasr City.

Anatomy

ANATOMY

Abdominal Wall Regions

In order to accurately describe the locations of visible abnormalities, masses, and pain in a typical clinical work, the

anterolateral abdomen is divided into nine regions by four imaginary planes, Two verticals (mid-clavicular/mid-inguinal) and two horizontal (transpyloric/intertubercular) planes (Figure1).

The transpyloric plane corresponds to the midpoint between the umbilicus and xiphoid process, crossing the pylorus of the stomach at the lower border of the first lumbar vertebra. The subcostal plane that passes across the costal margins and the upper border of the third lumbar vertebra may be used instead of the transpyloric plane. The lower horizontal plane, designated as the intertubercular line, traverses the anterior abdomen at the level of fifth lumbar vertebra, and connects the iliac tubercles on both sides **(Snell 2012).**

A second lower horizontal plane, the interspinous plane, may also be used, interconnecting the anterior superior iliac spines on both sides and running across the sacral promontory **(Snell 2012).**

Of the nine areas, the centrally placed zone is the umbilical region (Figure 1). This region surrounds the umbilicus and usually corresponds to the location of the jejunum, transverse part of the duodenum, terminal ileum, transverse colon, ureter and the greater curvature of the stomach **(Snell 2012).**

The epigastrium is the upper middle part of the anterior abdomen between the umbilicus below and the costal arches and the xiphoid