سامية محمد مصطفى

شبكة المعلومات الجامعية

بسم الله الرحمن الرحيم

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التوثيق الالكتروني والميكروفيلم

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جامعة عين شمس

التوثيق الإلكتروني والميكروفيلم

قسم

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها علي هذه الأقراص المدمجة قد أعدت دون أية تغيرات

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بالرسالة صفحات لم ترد بالأصل

LAPAROSCOPIC CHOLECYSTECTOMY IN ACUTE CHOLECYSTITIS

THESIS

Submitted for partial fulfillment of Master Degree in
Hepatobiliary Surgery

By

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INTRODUCTION & AIM OF WORK

INTRODUCTION

Laparoscopic cholecystectomy has become the treatment of choice for many patients with symptomatic cholelithiasis. The advantages of laparoscopic cholecystectomy over traditional open cholecystectomy in terms of limited postoperative pain, shorter hospitalization, earlier resumption of activity and improved cosmoses have been readily apparent. (Deziel et al, 1993).

Acute cholecystitis has been considered a contraindication to performing laparoscopic cholecystectomy because of perceived technical difficulties. (Larson et al, 1992).

The presence of empyema or severe inflammation of the gallbladder was initially regarded as a contraindication to this technique (Reiss et al, 1990). In addition there was a belief that the complication rate and the risk of major duct injury may be higher (Flowers et al, 1991).

Greater experience with laparoscopic cholecystectomy has led many centres to attempt laparoscopic cholecystectomy in patients with a diagnosis of acute cholecystitis (Cuschieri et al, 1991).

Zucker et al, 1993 concluded that laparoscopic cholecystectomy appears to be a safe and beneficial option in selected patients with acute cholecystitis and a low threshold for

conversion to laprotomy appeared to be an important factor in maintaining a low incidence of operative complications.

Krahenbuhl and Buchler (1996) said that laparoscopic cholecystectomy for acute cholecystitis is feasible and safe and shown the same mortality and common bile duct injury as in elective cases, but there is a slightly increased morbidity rate and markedly increased conversion rate, though mainly for difficult cases.

AIM OF THE WORK

The aim of this work is to evaluate the safety and efficacy of laparoscopic cholecystectomy in management of acute cholecystitis.

REVIEW OF LITERATURE

LAPAROSCOPIC ANATOMY OF THE BILIARY TREE

Thorough knowledge of anatomy, the foundation for the safe conduct of all operative procedures, is especially critical in laparoscopic procedures (Adams, 1993).

What Maingot said for open cholecystectomy is true for laparoscopic cholecystectomy: The surgeon "should work by sight and not by faith". (Maingot. 1969).

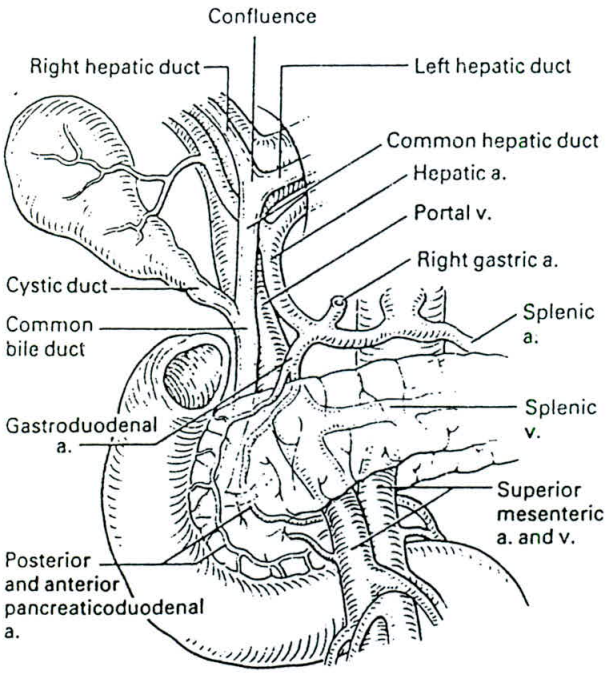
ANATOMY OF EXTRAHEPATIC BILIARY TREE

Hepatic Ducts :

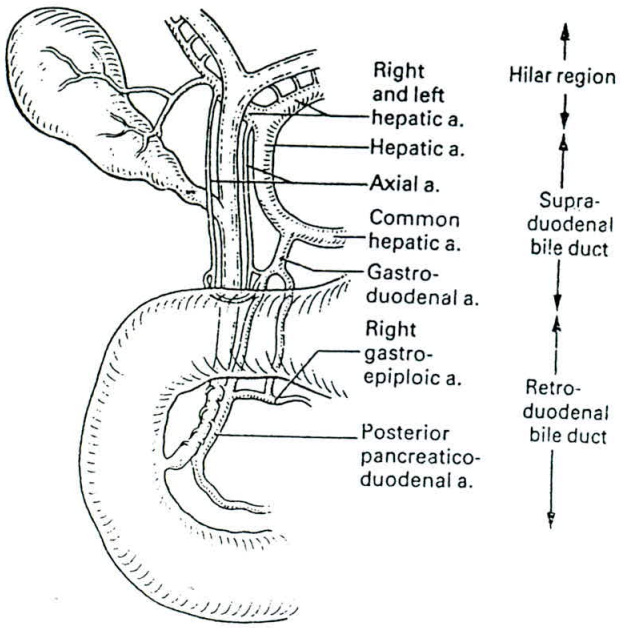
The biliary drainage of the right and left liver is into the right and left hepatic ducts respectively. The left hepatic duct is formed within the umbilical fissure from the union of the three segmental ducts draining the left liver (segment II, III and IV). The right hepatic duct drains segment V, VI, VII and VIII (Crist and Gadacz, 1993).

The right hepatic duct is formed by the intrahepatic confluence of dorsocaudal and ventrocranial branches. It enters with a sharp curve. (Schwartz, 1988).

The biliary drainage of the caudate lobe (segment I) is variable. In approximately 80% of individuals, the caudate lobe



Extrahepatic biliary anatomy



Blood, lymphatic and nerve supply

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