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شبكة المعلومات الجامعية

التوثيق الالكتروني والميكروفيلم

شبكة المعلومات الجامعية

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قسم

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

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تحفظ هذه الأقراص المدمجة بعيدا عن الغبار

Laparoscopic Cholecystectomy after Endoscopic Retrograde Cholangiopancreatography

Thesis

Submitted for Partial Fulfillment of Master Degree in **General Surgery**

By

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M.B.B.CH

Under Supervision of

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Ahmed Kamal Mohammed Mohammed

ABSTRACT

Background: Laparoscopic cholecystectomy (LC) post Endoscopic retrograde cholangiopancreatography (ERCP) with endoscopic sphincterotomy(ES) is generally accepted as the treatment of choice for patient with choledococystolithiasis. Previous studies have shown that LC after ERCP is associated with a high conversion rate. The aim of the present study was to assess the complexity of LC after ERCP compared with standard LC for symptomatic uncomplicated cholecystolithiasis.

Objectives: So the aim of this study is to assess the complexity of LC post ERCP comparted to elective LC without previous ERCP.

Method: The study is a prospective cohort study of two groups of patients: patients who had undergone a previous ERCP for choledocolithiasis (PES) and patients with cholecystolithiasis who had no previous intervention prior to LC (NPES).

Results: The PES group consists of 25 patients and the NPES group consists of 25 consecutive patients, patients in the PES group had a higher risks for longer (more than 35 min) duration of operation, the conversion rate in the PES group and the NPES group (12% versus 0%, respectively) were not significantly different, duration of post-operative hospital stay in the PES group was longer than NPES group, there was more difficulty in achieving the critical view of safety in the PES group (easily achieved in 48%) than NPES group(easily achieved in 92%).

Conclusion: A laparoscopic cholecystectomy after ES is longer and more difficult than in uncomplicated cholelithiasis and should therefore be performed by an experienced surgeon.

Keywords: Laparoscopic Cholecystectomy, Endoscopic Retrograde, Cholangiopancreatography

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List of Abbreviations

Abb.	Full term
ALT	*Alanine aminotransferase*
ASGE	*American Society for Gastrointestinal Endoscopy*
AST	*Aspartate aminotransferase*
BMI	*Body mass index*
CBD	*Common bile duct*
CHD	*Common hepatic duct*
ELC	*Elective laparoscopic cholecystectomy*
ERCP	*Endoscopic retrograde cholangiopancreatography*
ES	*Endoscopic sphincterotomy*
EUS	*Endoscopic ultrasonography*
GB	*Gall bladder*
IOC	*Intraoperative cholangiography*
LC	*Laparoscopic cholecystectomy*
MRC	*Magnetic resonsnt cholangiography*
TUS	*Transabdominal ultrasound*
UGI	*Upper gastrointestinal*

INTRODUCTION

Endoscopic retrograde cholangiopancreatography (ERCP) is indicated for those patients who have clinical features and radiologic evidence of CBD stones ***(Patreson et al., 2009).***

Elective laparoscopic cholecystectomy (ELC) has an increased risk of complications after ERCP, with reports of longer operating times, increased bleeding, and higher rates of conversion to open surgery ***(Chandio et al., 2009).***

Previous studies have shown that LC after ERCP is more difficult than LC for uncomplicated cholelithiasis (***Bostanci et al., 2010).***

The conversion rate after a previous ERCP has been reported to be as high as 8–55% versus lower than 5% in patients with uncomplicated disease ***(Salman et al., 2009).***

The aetiology is thought to be because of disruption of the sphincter of Oddi and subsequent bacterial colonization of the biliary tract leading to inflammation and subsequent scarring of the hepatoduodenal ligament hindering dissection of Calot's triangle, This theory of reflux and bacterial colonization is strengthened by the finding that bile in patients who have undergone a sphincterotomy is colonized in approximately 60% of patients ***(Reinders et al., 2011).***

Laparoscopic cholecystectomy is more difficult after a previous ERCP it might be beneficial to have these patients operated on by an experienced laparoscopic surgeon to minimize the risk of conversion and subsequent morbidity ***(Ellen et al., 2013).***