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ROLE OF SURGERY IN CHRONIC NON-CALCULAR CHOLECYSTITIS

THESIS

SUBMITTED IN PARTIAL FULFILMENT FOR THE M.D DEGREE IN SURGERY

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DEDICATION

This work is dedicated to the memory of professor Dr. **Mohey El-Din Sedky**, the original architect of this thesis.

Dr. **Sedky** was a wonderful man, an outstanding surgeon, administrator and leader. Perhaps, his best moments, however, were as a teacher, where his instinct, knowledge, enthusiasm and sympathy were so evident and has such an inspiring effect.

Without him this work would not see the light of day

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CONTENTS

INTRODUCTION

The subject of chronic cholecystitis is confusing because the term has been used inconsistently within and between the specialties of surgery, internal medicine, and pathology.

The radiologic diagnosis is difficult because of the variable criteria by which the term is defined.

Although most cases of chronic cholecystitis are accompanied by stones, 95 percent, in order to understand this condition it is best to consider the problem of acalculous chronic cholecystitis. This is because when stones are present they will dominate the clinical thinking and the surgical approach. They will be assumed to be the cause of symptoms and will be the key in the diagnostic imaging evaluation.

This is not the case of chronic cholecystitis in the absence of stones where the diagnosis involves evaluating the extent and degree of changes and determining a threshold to call abnormal. (Zeman, et al, 1987).

* Many clinicians have included under the designation of chronic noncalculous cholecystitis a variety of conditions including allergic reaction of the gall bladder, metabolic

disorders, cholesterolosis, irritative states of the gall bladder due to toxic substances, biliary dyskinesia of various types, and cholecystitis glandularis proliferans (adenomyomatosis).

Others would like to see the term chronic non calculous cholecystitis applied exclusively to cases of chronic alithiasic inflammation, i.e., cases in which the mucosa of the gall bladder is destroyed or injured, with infiltration of lymphocytes and fibrosis of the wall.

* Over the past 50 years the surgeons have become increasingly hesitant to do cholecystectomy when the gall bladder does not contain stones, unless it is acutely inflamed.

But, recently, after the introduction of new methods in investigations namely, cholecystokinin test (CCK), and ultrasonography, many authors have reported better diagnostic index and consequently higher cure rates.

However how many patients have relief because of the "Placebo effect" of surgery, is unknown. (Nahrwald, DL 1986).

* Recently published clinical studies have presented evidence which suggests that prolonged visualization of acalculous gall bladders following oral cholecystography is invariably

indicative of cholecystitis or biliary dyskinesia.

Almost certainly, an upper gastrointestinal series to exclude the presence of esophageal, gastric or duodenol pathologic findings is a necessity in the evaluation of patients with prolonged visualization, because symptoms referable to these organs are often non specific and overlap with those of gall bladder disease. (Powell, et al 1981).

* In this study, we will confine the discussion of the presence of chronic acalculous cholecystitis and will assess the clinical problem, analyse the radiological changes on cholecystography and ultrasonography, review the various pathological changes in the gall bladder wall, chemical changes in the bile and will record the results of cholecystectomy to show the role of surgery in that problem.

ANATOMICAL CONSIDERATIONS

ATOMY OF THE GALL BLADDER

The gall bladder and cystic duct develop from the caudal branch of the hepatic diverticulum, while the epithelium of the bile ducts develops from the cranial branch.

The gall bladder is a pear-shaped sac, about 7 cm long, with a normal capacity of about 30 - 60 mL. It is oblique in position, its long axis being directed backwards, upwards and slightly medially from the lower edge of the liver to the right end of the porta hepatis.

The main part is the body which adheres to the gall bladder fossa or bed on the visceral surface of the liver between the quadrate and right anatomical lobes. Its lowest part, the fundus, which is enclosed on all sides with peritoneum, may project below the inferior border of the liver. It touches the anterior abdominal wall at a varying point, but very frquently opposite the upper end of the linea semilunaris immediately below the ninth costal cartilage (Murphy's point).

The body narrows to form the neck which becomes continuous with the cystic duct. (Romanes, 1971).

The gall bldder is held in position in the gall bladder fossa partly by loose aerolar tissue and by small veins that pass from it into the liver, but chiefly by the hepatic peritoneum which passes across its lower surface from margin of the fossa

to the other, covering it except for the surface that is in direct contact with the liver; occasionally it may be completely invested with the peritoneum which becomes connected to the liver by a short or long mesentery.

The relations of the gall bladder

Anteriorly, the liver and the anterior abdominal wall in the region of the ninth costal cartilage.

Posteriorly, the junction of the first and second parts of the duodenum. Above the liver and below, the transverse colon.

The wall of the neck is attached to the liver by aerolar tissue in which the cystic artery is present, and where it becomes the cystic duct where it may show a small diverticulum, the Hartmann's pouch, which, although originally described by Broca and considered a constant feature of the gall bladder, yet it is now known not to be a feature of the normal gall bladder and it is always associated with pathological conditions specially dilatation, which when present, the cystic duct arises from its upper end and left wall (Mc Minn, 1981). The mucous membrane which lines the neck projects into the lumen in the form of oblique ridges forming a sort of spiral valve. When the neck is distended this valve causes the surface of the neck to present a spiral constriction, that is why the gall bladder is not a good bypass drainage in obstructive jaundice.

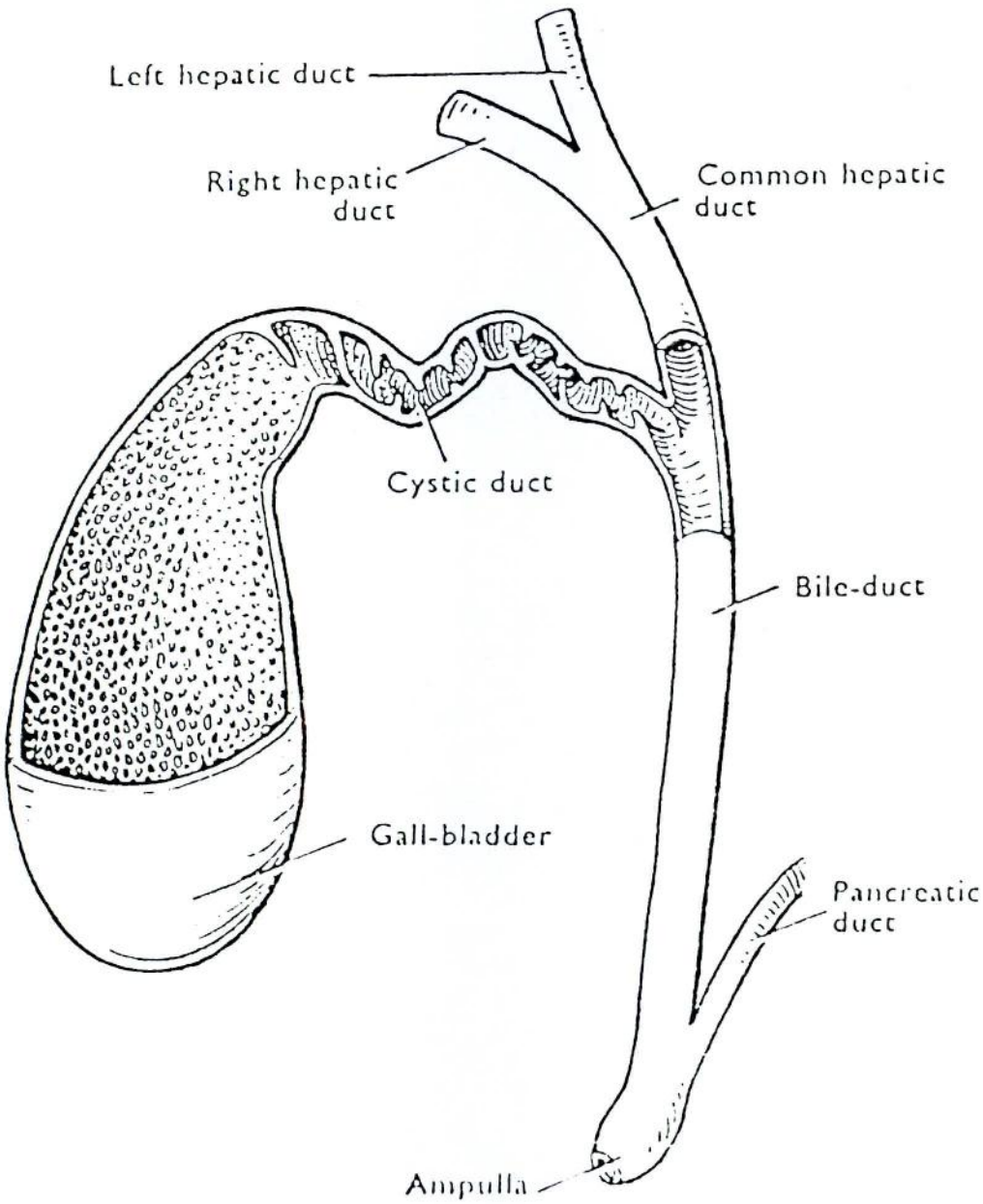

Fig. 1 A diagram of the extahepatic parts of the biliary system.
(Romanes, 1971)