

Analysis of the Results of Laparoscopic Cholecystectomy in Patients with Acute Cholecystitis

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Introduction

The urgency of the problem of surgical treatment of acute cholecystitis is due to the non-decreasing incidence rate and stable mortality rates. Advances in endovideolaparoscopic technologies in the diagnosis and treatment of a number of diseases of the abdominal organs (appendicitis, hernia repair). perforated gastroduodenal ulcers, peritoneal adhesive disease) are undeniable. However, along with undeniable advantages, laparoscopic cholecystectomy (LC) has also posed a number of complex problems for surgeons, one of which is intraoperative complications. Over the years, their frequency has remained stable, unacceptably high and, according to various authors, is 1.5–16.8%. Despite the successes achieved in laparoscopic surgery, in the treatment of cholelithiasis, the prevention of intraoperative complications remains an urgent and complex problem and is not sufficiently covered in the literature.

Purpose of the study

Analyze the results of laparoscopic cholecystectomy (LCE) in patients with acute cholecystitis, the causes of complications when performing laparoscopic procedures for their interventions and develop measures aimed at their prevention.

Materials and research methods.

The results of surgical treatment of 387 patients with acute calculous cholecystitis aged 28 to 63 years who were admitted to the emergency abdominal department of the Fergana branch of the RRCEM in the period from 2015 to 2019 were analyzed. As an examination, patients underwent general clinical, biochemical and instrumental examinations (ultrasound, CT) to determine the nature of their lesions, as well as, according to indications, an endoscopic papillos copy and endoscopic retrograde cholangiopancreatography (ERCP).

Research results and discussion

The conducted studies showed that among the admitted patients, operated women accounted for 271 (70%) and 116 (30%) men.

In those with acute calculous cholecystitis, acute catarrhal cholecystitis was diagnosed in 134 (34.6%) patients, acute phlegmonous cholecystitis in 172 (44.4%) patients. (%) and gallbladder gangrene was diagnosed in 81 (20.9%) patients. In 137 (35.4%) patients, destructive changes in acute calculous cholecystitis were noted: 65 (16.8%) - dropsy of the gallbladder, 30 (7.8%) - gallbladder empyema, 31 (8%) of the patients were diagnosed with mechanical jaundice, which was caused by pericholedochal lymphadenitis and choledocholithiasis in 25 (11.6%) cases. In 156 (40.3%) patients, local peritonitis was diagnosed without violating the integrity of the gallbladder wall, in 41 (10.6%) patients, a perivesical infiltrate formed around the gallbladder, in another 34 (8.8%) patients, the course of the disease was complicated by a perivesical abscess. In 7 (1.8%) patients with signs of obstructive jaundice, Mirrizi's syndrome was diagnosed: a stone in the neck of the bladder squeezed the choledochus, causing cholestasis - at the level of the common hepatic duct.

All patients with acute calculous cholecystitis underwent laparoscopic cholecystectomy within 1 to 2 days from the moment of admission. Intraoperative complications requiring conversion occurred in 19 (4.9%) patients. Their cause was the difficulty in isolating the cystic duct and the feeding artery from a dense infiltrate in the area of the hepatoduodenal ligament. In these cases, antegrade removal of the

gallbladder was performed after upper midline laparotomy . Damage to the main bile ducts and blood vessels, as well as deaths during laparoscopic There was no cholecystectomy in patients with acute cholecystitis.

In patients with an acute course of cholelithiasis (GSD) and an established cause of changes in the choledochal cavity , treatment began with endoscopic sanitation of the extrahepatic biliary tract. Thus, in 35 (9%) patients with BD stenosis, endoscopic papillosphincterotomy (EPST) was performed, and a day later, laparoscopic cholecystectomy (LCE) was performed. Patients with choledocholithiasis (75 (19.4%)) underwent EPST , or traction and nasobiliary drainage (NBD) of the choledochus . In those cases when it was not possible to extract calculi from the choledoch at once , NBD was left for a longer time. The passage of stones from the choledochus was controlled using ERCP. When X-ray confirmation of the absence of stones in the lumen of the choledochus was performed laparoscopic cholecystectomy .

In 28 (7.2%) patients, the operation had to be completed by the open method. At the same time, prudence conversion was performed in 20 patients. Its cause in 14 (3.6%) patients was sclerotic changes in the gallbladder neck and hepatoduodenal ligament, which made it difficult to visualize the main structures of the Calot triangle . In 4 (1%) cases, there was a massive adhesive process after previously performed operations on the stomach and duodenum. In 10 (2.6%) subjects , conversion "as needed" was performed. Its cause was: in 1 (0.26%) case there was a marginal wound of the common bile duct , in 2 (0.52%) cases there was bile leakage from the additional bile duct in the projection of the gallbladder bed; bleeding from the gallbladder bed , which could not be stopped by electrocoagulation, occurred in 3 (0.78%) cases.

During the operation, in patients with sclerotic changes in the area of the gallbladder neck, an antegrade cholecystectomy . _ Retrograde cholecystectomy was performed in patients with massive adhesions after separation of adhesions . In cases of marginal injury of the choledochus , its external - drainage was performed through the injury site. In case of bile leakage from the accessory bile duct in the area of the gallbladder bed, its ligation was performed. In 3 (0.78%) patients with bleeding from the gallbladder bed, the blood of the effluent vessel was sutured. 2 (0.52%) elderly patients died. In one case, the cause of death was acute cardiovascular failure . In the second - pulmonary embolism.

In the late period, two patients with biliodigestive anastomoses developed a clinical picture of cholangitis, which was confirmed by ultrasound data and clinical and laboratory studies . These patients underwent conservative therapy, including antibacterial drugs, antiplatelet agents , vitamins, and hepatoprotectors .

A retrospective analysis of the complications that arose during LCE and required a change in access showed that the main reasons that led to the conversion should be considered inadequate interpretation of the preoperative examination data, as well as the lack of consideration of possible technical difficulties in the upcoming operation due to incorrect interpretation of the anamnesis data. , as well as the results of instrumental research methods. To prevent the failures and errors that occur during LCE from developing into serious complications, it is necessary to carefully consider the data on the state of the gallbladder and ducts obtained by ultrasound and ERCP, and also strictly observe the staging of surgical interventions. To prevent open intervention by "prudence", it is necessary to determine the form of inflammation of the gallbladder, the structure of its wall and elements of the hepatoduodenal ligament, as well as the presence of perivesical complications before the operation.

Conclusions

Thus, the correct interpretation of the history data , as well as the results of the preoperative examination, makes it possible to predict possible technical difficulties in future surgical interventions.

Laparoscopic cholecystectomy should begin with a diagnostic video laparoscopy, according to which the possibility of performing laparoscopic interventions in each specific case is determined.

Videolaparoscopy should be considered not as a stage of the operation, but as a diagnostic method that is of decisive importance in choosing the method of surgical treatment in patients with acute cholecystitis.

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