

## Summary

In our study , laparoscopic cholecystectomy was performed on 500 patients with symptomatic gall bladder disease, 450 patients of them with chronic calculous cholecystitis, 15 patients with chronic non calculous cholecystitis and 35 patients with acute calculous cholecystitis.

Thorough history taking , physical examination and proper investigations were carried out to determine the presence of biliary and non biliary problems that may adversely affect the outcome of laparoscopic cholecystectomy .

Biliary problems included 10 patients who had stone common bile duct with chronic calculous cholecystitis . They managed with preoperative E.R.C.P. with stone extraction prior to laparoscopic cholecystectomy, which was successfully performed in these patients , non biliary problems , included patients with cardiopulmonary disease, coagulopathy, cirrhosis, morbid obesity and previous abdominal surgery, so further evaluation and cautious approach to the management of these individuals had been taken.

Despite the liberalization of patients selection, not all individuals were candidates for laparoscopic cholecystectomy - Our absolute contraindications included inability to tolerate general anaesthesia or laparotomy , uncorrected coagulopathy and generalized peritonitis.

laparoscopic cholecystectomy started through 3 puncture technique in 10 patients, 4 puncture technique in 460 patients and insertion of accessory fifth cannula was needed in 20 patients due to operative difficulties .

So, closed laparoscopic technique was carried out in 490 patients whereas open laparoscopy (Hasson Technique) was performed in 10 patients.

In our work , we were confronted with about 17 different difficulties which was identified in 290 patients (58%) . Three conditions, morbid obesity , history of previous upper abdominal surgery and presence of umbilical hernia specifically interfere with the ability of the surgeon to gain access to the abdominal cavity for laparoscopic cholecystectomy .

Conversion to open cholecystectomy happened in two patients (0.4%) . In a patient conversion was performed for safety due to presence of dense extensive adhesions (early mass) in cirrhotic patient with obscured anatomy and dissection was so risky that vital structures might be injured . In the other case conversion was carried out due to complication as there was injury of common bile duct which was mistaken for the cystic duct probably due to upward distraction of the bile duct by the cephalad traction applied to the neck of the gall bladder .

In our work , complications of laparoscopic cholecystectomy happened in 65 patients (13%), they were either due to operative or postoperative complications as a result of abnormal finding. These

complications were mostly of the minor type and were managed conservatively.

Serious intraoperative complications during the procedure were infrequent . In our study, injury common bile duct happened in one case (0.2%) which was detected intraoperatively, conversion to open cholecystectomy , repair with Choledochoduodenostomy, and placement of closed suction drain were carried out.