INTRODUCTION

Laparoscopic cholecystectomy is the most significant technical advance in performing cholecystectomy since first described as an open procedure in 1882 by Langenbuch . After 110 years as the treatment of choice for symptomatic cholelithiasis , open cholecystectomy has been supplanted by laparoscopic cholecystectomy as the technique of choice to remove the gall bladder in less than 5 years after the first successful laparoscopic cholecystectomy reported by *Dubois et al.* in France . (137)

The foundation of modern common bile duct exploration was laid by *Ludwig Courvoisier* in 1890 with the first successful removal of common bile duct stones . For generations since this historical event operative exploration of the common bile duct at the time of cholecystectomy has been considered the benchmark to which all other treatment modalities are compared . With the advent of laparoscopic cholecystectomy , common bile duct stones were once again out of the reach of most surgeons . To the newly aquired skills of laparoscopy , intra-operative cholangiography and common bile duct exploration posed added technical challenges .(140)

There is as yet , no consensus regarding the management of common bile duct stones found during laparoscopic cholecystectomy . Among the methods proposed are postoperative endoscopic retrograde cholangio-pancreatography with endoscopic sphincterotomy , transcystic laparoscopic techniques and conversion to open common bile duct

exploration . When common bile duct stones are found at the time of laparoscopic cholecystectomy , the surgeon must choose from among these options .[96]

Few laparoscopic surgeons currently explore the bile duct at laparoscopic cholecystectomy , this has focused attention on the role of preoperative endoscopic retrograde cholangiopancreatography in the diagnosis and treatment of duct stones .[138]

Evidence from open cholecystectomy suggests that 2-12% of patients with no preoperative evidence to suggest duct stones will have such stones demonstrated on operative cholangiography , intravenous cholangiography has been generally regarded as diagnostically inferior to operative cholangiography . Hence, in some centers operative cholangiography has become an integral part of laparoscopic cholecystectomy . This maneuvre may increase the difficulty and duration of the laparoscopic procedure and in its own right is not of course completely accurate . The argument that ductal injuries can be prevented by routine operative cholangiography may also be invalid . Injury to the bile duct is mainly a technical problem and many strictures occur after intraoperative clamping or diathermy in presence of bleeding. This should be prevented by careful technique and applies equally to laparoscopic cholecystectomy as to open cholecystectomy , thus the key to avoid duct injuries is meticulous demonstration of anatomic details at operation .[24]

In the era of laparoscopic cholecystectomy , the indications for cholangiography and the strategies for management of common bile duct stones need to be re-evaluated . In conclusion , endoscopic retrograde cholangiopancreatography prior to laparoscopic cholecystectomy is not useful as a routine procedure but should be restricted to patients in whom choledocholithiasis is suspected . In case of common bile duct stones detected preoperatively , endoscopic papillotomy plus subsequent laparoscopic cholecystectomy seems to be a valuable therapeutic approach with minimal invasion promising short hospitalisation period.[95]

The aim of this work is to determine the efficacy and safety of E.R.C.P and laparoscopic cholecystectomy in the management of patients with chronic calcular cholecystitis and suspected choledocholithiasis .