Complication of laparoscopic cholecystectomy

Ahmed Abdel Aziz Azzam

In our study, lapardscopic cholecystectomy was performed on 500patients with symptomatic gall baldder disease, 450 patients of them withchronic calcular cholecystitis, 15 patients with chronic non calcularcholecystitis and 35 patients with acute calcular cholecystitis.Thorough history taking , physical exammation and properinvestigations were carried out to detennine the presence of biliary andnon biliary problems that may adversely affect the outcome oflaparoscopic cholecystectomy.Biliary problems included 10 patients who had stone common bileduct with chronic calcular cholecystitis. They managed with preoperativeE.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 furtherevaluation and cautious approach to the management of these individualshad been taken.Despite the liberalization of patients selection. not all individualswere candidates for laparoscopic cholecystectomy - Our absolutecontraindications included inability to tolerate general anaesthesia orlaparotomy, uncorrected coagulopathy and generalized peritonitis.183laparoscopic cholecystectomy started through 3 puncture techniquein 10 patients, 4 puncture teclmique in 460 patients and insertion ofaccessory fifth cannula was needed in 20 patients due to operativedifficulties.So, closed laparoscopic technique was carried out in 490 patientswhereas open laparoscopy (Hasson Teclmique) was perfonned in 10patients.In our work, we were confronted with about 17 different difficultieswhich was identified in 290 patients (58%) . Three conditions, morbidobesity , history of previous upper abdominal surgery and presence ofumblical hemia specifically interfere with the ability of the surgeon to gainaccess to the abdmominal cavity for laparoscopic cholecystectomy.Conversion to open cholecystectomy happened in two patients(0.4%) . In a patient conversion was perfonned for safety due to presenceof dense extensive adlH~sions (early mass) in cirrhotic patient withobscured anatomy and dissection was so risky that vital structures mightbe injured . In the other case conversion was carried out due tocomplication as there was injury of common bile duct which was mistakenfor the cystic duct probably due to upward distraction of the bile duct bythe cephalad tractign applied to the neckof the gall bladder.In our work , complications of laparoscopic cholecystectomyhappened in 65 patients (13%), they were either due to operative orpostoperative complications as a result of abnormal finding. These184complications were mostly of the nunor type and were managedconservatively.Serious intraoperative complications during the

procedur~ wereinfrequent. In our study, injurycommonbile duct happened in one case(0.2%) which was detected intraoperativly, conversion to opencholecystectomy , repair with Choledochoduodenostomy, and placementof closed suction drain were carried out.