Complications of cholecystectomy

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Recovery after laparoscopic cholecystectomy is associated with less pain and faster return to normal activity than open cholecystectomy . The majority of elective patients can have this performed as a day case; however, any patient looking unwell in the postoperative period, with untoward symptoms such as fever, chills or abdominal pain, should be kept under observation. Complications can occur in 10–15% of cases. Serious com - plications fall into two major areas: access complications and bile duct injuries. The latter are rare, occurring in approxi - mately 0.5% following laparoscopic cholecystectomy . In the main, biliar y injury results from poor dissection and a failure to define the surgical anatomy adequately . Controversy exists as to whether operativ e cholangiography reduces the incidence of bile duct injury . The majority of surgeons use cholangi - ography only in selected cases. The operative mortality for cholecystectomy is less than 1%. Factors increasing the risk for postoperative mortality include advanced age, comorbid conditions and an acute presentation. - Patients who develop jaundice in the postopera tive period need urgent investigation. This is especially true if the jaundice (b) (a) is attributed to infection and cholangitis. The first step follow ing resuscitation and administration of appropriate antibiotics is to undertake urgent USG. This will demonstrate whether there is intra- or extrahepatic ductal dila tation. The anatomy may need to be defined by MRCP or ERCP . The latter is undertaken when therapeutic manoeuvres are planned, such as the removal of an obstructing stone or the insertion of a stent across a biliary leak. If a fluid collection is present in the subhepatic space, drainage catheters may be required. These can be inserted under radiological control or, if this expertise is not available, at open operation. Small biliary leaks will usually resolve spontaneously , especially if there is no distal obstruc tion. If the CBD is damaged, the patient should be referred to an appropriate expert for reconstruction.

<2 cm

> 2 cm E1 E2 E3 Figure 71.33 Schematic representation of the Strasberg classi /f_i cation of bile duct injuries. biliary radical in the gallbladder fossa. (b) An occluded right posterior sectoral duct. duct. (d) A bile leak from the main bile duct without any major tissue loss. the hilus. E2 , transected main bile duct with a stricture less than 2 cm from the hilus. communication. E4 , stricture of the hilus with separation of the right and left hepatic ducts. duct and the main bile duct. E6 , complete excision of the extrahepatic ducts involving the con /f_l uence (this injury is not described in Strasberg’s classi /f_i cation). (After Connor

> S, Garden OJ. Bile duct injury in the era of laparoscopic cholecystectomy.

Revision #1
Created 2025-12-31 15:26:39 UTC by Omar Ayman
Updated 2025-12-31 15:26:39 UTC by Omar Ayman