Long-term problems following liver trauma and thei

Long-term problems following liver trauma and their management

Late complications are rare, but biliary strictures occur many years after liver trauma and treatment depends on the extent and site of stricturing. A segmental or lobar stricture with atrophy of the corresponding area of liver parenchyma and compensatory contralateral hypertrophy is treated expectantly . A dominant extrahepatic bile duct stricture associated with obstructive jaundice should be treated endoscopically but may require surgical correction with a Roux-en-Y hepatodochoje - - junostomy .

Surgery Becomes Uneventful unstable • Manage complications Remains • Haemorrhage stable • Reactionary and secondary haemorrhage • Biliary • Vascular • Sepsis • Other associated injuries

Portal hypertension is most commonly due to liver cirrhosis, although it also occurs with extrahepatic portal vein occlusion, intrahepatic veno-occlusive disease and occlusion of the main hepatic veins (Budd–Chiari syndrome). The condition is common in clinical practice and portal hypertension represents a significant clinical challenge, with patients who have often been ill for long periods repeatedly presenting as emergencies. Many symptoms are intractable, surgery is technically di ffi cult and procedures and timing must be chosen with extreme care. Portal hypertension per se produces no symptoms and is generally diagnosed following presentation with decompen sated chronic liver disease causing encephalopathy , ascites or variceal bleeding (Figure 69.12). Surgical involvement occurs in four situations: 1 ascites; 2 oesophageal varices; 3 portosystemic shunting for problems not managed by other methods; 4 left-sided portal hypertension and hypersplenism.

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