



Study of Presentation, Evaluation and Management of Obstructive Jaundice in Osmania General Hospital

KEYWORDS

Obstruction, Jaundice, surgical jaundice

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ABSTRACT

The study is aimed at evaluating the various causes, presentation and management of obstructive jaundice in Osmania General Hospital. The study was conducted among 40 cases who presented to Osmania general hospital with complaints of jaundice and were found to have a surgical jaundice between march 2013 to February 2015.

INTRODUCTION:

Jaundice is a term for the yellow pigmentation of skin, mucous membranes or sclera that is caused by heterogeneous group of disorders.

The clinical manifestations of jaundice are direct result of increased levels of bilirubin, a normal metabolite of hemoglobin. Normal bilirubin concentration ranges from 0.2-1.0mg/dL. Jaundice is clinically apparent when serum bilirubin level is more than 2.5mg/dL. Jaundice in itself is not a disease. It is a symptom of an underlying disorder, the differential diagnosis of which is varied. Depending on etiology. Jaundice is broadly classified into

- Hepatocellular jaundice
- Haemolytic jaundice
- Cholestatic or obstructive jaundice

For management purpose jaundice is broadly divided into

- Medical jaundice
- Surgical jaundice

Medical jaundice is the term used for broad range of disorders that do not require surgical intervention. It has both hepatocellular and hemolytic jaundice with predominant unconjugated hyperbilirubinemia.

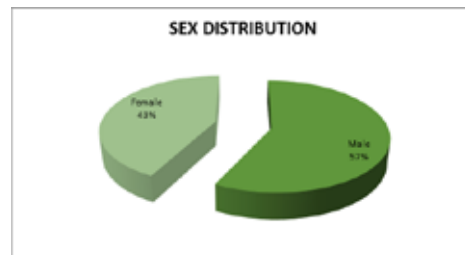
Surgical or obstructive jaundice results from mechanical obstruction to flow of bile with predominant conjugated hyperbilirubinemia.

MATERIALS AND METHODS**INCLUSION CRITERIA:**

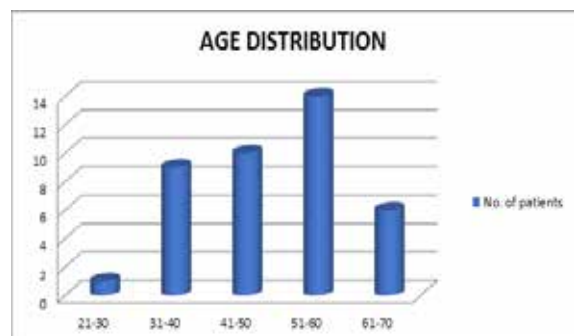
- Patients who presented to Osmania general hospital with complaints of jaundice and were found to have a surgical jaundice.
- Age should be between 20 and 70 yrs.
- Documented obstructive jaundice by biochemical or radiological investigations (S.bilirubin more than two or Vandenberg positivity or dilated biliary system).
- Should not have undergone any form of drainage procedure like ERCP, PTC .
- Underwent surgery in department of surgery in Osmania general hospital.

ANALYSIS OF RESULTS**SEX DISTRIBUTION****(N=40)**

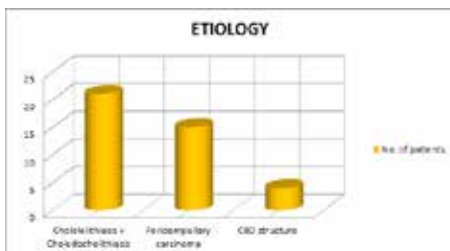
Sex	No. of patients	Percentage1
Male	23	58%
Female	17	42%

**AGE DISTRIBUTION****(N=40)**

AGE	No. of patients	Percentage1
21-30	1	2.5%
31-40	9	22.5%
41-50	10	25%
51-60	14	35%
61-70	6	15%

**AGE DISTRIBUTION BY CAUSE**

Majority of benign causes were seen in 30-50 yrs. age group while majority of malignant causes were seen in older age group of 50 – 70.



ETIOLOGY (N=40)

ETIOLOGY	No. of patients	Percentage1
Cholelithiasis + Choledocholithiasis	21	52.5%
MALIGNANT OBSTRUCTION	15	37.5%
CBD stricture	4	10%

DISCUSSION

AGE DISTRIBUTION

A total of 40 patients were included in this study the youngest patient was 27 years and oldest was 66 years. Mean age of patient was 46.5 years.

SEX DISTRIBUTION

Male to Female ratio in our study was 1.4:1 (M:F). Although the incidence of obstructive jaundice is more common in females due to higher incidence of choledocholithiasis contrary findings were due to inclusion of cases who underwent a surgical procedure.

SYMPTOMATOLOGY

The most common symptom in our study was jaundice (100%) followed by pain abdomen (70%), pruritus was present in 65% case and scratch marks were seen in around 60% patients. Fever was present in 40% patients.

ETIOLOGY

The most common cause obstructive jaundice in our study was choledocholithiasis 52.5% followed by malignant obstruction 37.5% then by CBD stricture 10%.

In this study only the cases which were operated on for obstructive jaundice were included. Although the incidence of malignant obstructive jaundice is higher than benign causes but many cases of malignant obstruction have presented at a stage of inoperability and were excluded from the study.

CONCLUSION

The obstructive lesions of the biliary system are difficult problems for the surgeon as most of the patients are old and poor surgical risk

This prospective study in a defined population revealed clinically the causes of obvious obstructive jaundice in our setting over 24 months period, the jaundice being proven by history, examination and laboratory investigations.

Majority of the patients in this study were due to choledocholithiasis as patients with inoperable malignancy were not included in the study.

Average age of patients with benign disease was around 50 years and those with malignant obstruction was 58 years.

The biochemical investigations done was LFT which showed elevated bilirubin and ALP levels.

Amongst the radiological investigations USG abdomen picked the dilated intrahepatic channels in 80%, the dilated extrahepatic channels in 85%.

ERCP was performed in most of the cases and it was able to pick up the cause wherever present. ERCP has been defined as a 'GOLD STANDARD' for the diagnosis of obstructive jaundice especially in cases of CBD stones.

CT scan was done for all cases suspected of malignancy and the ones in which ERCP was successful and the diagnosis was made on the basis of its findings. The poor prognosis was described to the patients who had large tumor size, locally advanced tumor, lymph node metastasis, distant metastasis. This probably reflects the delays in the presentations of the patients to the physician due to social and cultural factors.

Surgery for cases of obstructed jaundice proved to be the only treatment which improved the quality of life.

Cases of malignant obstruction were high risk cases with an acceptable mortality rates in our hospital.

Post op period was uneventful for most cases of benign diseases.

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