ORIGINAL RESEARCH PAPER

Volume-8 | Issue-2 | February-2019 | PRINT ISSN No 2277 - 8179

INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH

RELAPROSCOPY IN MANAGEMENT OF POST CHOLECYSTECTOMY PAIN DUE TO RESIDUAL STONE. IT'S SAFE IN EXPERIENCED HAND

General Surgery

Kusum Meena Professor,Department of Surgery ,Lady Hardinge Medical College

Brijesh Kumar Singh* Mch(Breast and Endocrinology) AIIMS,New Delhi*Corresponding Author

ABSTRACT

Background

Laparoscopic cholecystectomy is the commonly performed surgery worldwide .In experienced hands it is safe procedure but inexperience in understanding the difficult anatomy at calots and enthusiastic young surgeon who refuses for conversion to open puts patient in great trouble .Before applying clips viewing critical view of safety is of paramount importance .The incidence reported of residual gall stones is less than 2.5% in literature.

Case Report

We are reporting a case of 25 years old lady who was a case of symptomatic gallstone disease and simultaneously getting treatment for primary infertility. She underwent laparoscopic cholecystectomy that was reported to be uneventful with only inflammation in calots .The patient was discharged next day. In post operative period patient was regularly coming to OPD with complaint of pain in right hypochondrium.USG was done that revealed stone in GB fosse .Further MRCP was done which showed gall bladder remanant with stones in GB fossa region.CBD was normal. Patient was planned for relaparoscopy and proceeds, however consents were taken for conversion to open .But somehow we were lucky enough to perform it laparoscopically. There were adhesions between gall bladder remnant and omentum but separated with hydro dissection. Hydro dissection technique was used for identification of cystic duct and artery in calots and clipped separately. Patient was discharged after 2 days .She is symptom free in one year follow up period.

Conclusion

GB remnant containing stones is not the unusual cause for post cholecystectomy pain and completion cholecystectomy done ,open or laparoscopic offers definitive treatment. Inadequate dissection in calots ,unfamiliarity with difficult calots situation, leaving long cystic duct stump to avoid inadvertent injury to CBD ,partial cholecystectomy for mirrizzi,s syndrome are few causes for post operative pain. USG and MRCP plays prudent role in investigation .These patient should be given benefit of re -laparoscopy .The emphasis on reporting this case as we were able to perform laparoscopic completion cholecystectomy.

KEYWORDS

Gall bladder remnant ,Laparoscopic cholecytectomy, Post cholecystectomy pain, Relaparoscopy

INTRODUCTION

Laparoscopic cholecystectomy is the most commonly performed surgery worldwide and has achieved the status of gold standard surgery for symptomatic gall stone disease(1).Laparoscopic surgery must be performed expertly ,slowly, carefully by a well trained surgeon, or terrible consequences can occur. The biggest risk in laparoscopic GB surgery is having an untrained surgeon. Post cholecystectomy patients experiencing billary colic is not an uncommon entity and this becomes the indication for detailed workup .In literature the reported incidence of residual GB stones is less than 2.5%.(2)Post cholecystectomy syndrome-the recurrence of symptoms similar to those before the procedure occur in 10-40% of patients.(2,3)The time to the onset of symptoms can range from 2 days to up to 25 years .Women may be at higher risk ,with symptoms recurring in 43%vs28%in men.(4)Post cholecystectomy syndrome poses a diagnostic and therapeutic challenge and significant morbidity in post operative period. Though it has been reported since the advent of the operation, the increased incidence has been observed after LC.

CASE REPORT

We are reporting case of 25 years old lady who underwent laparoscopic cholecystectomy 3 months prior to current admission. She was asymptomatic for 10 days in postoperative period when she experienced colicky pain in right hypochondrium, similar to the pain, she used to have before LC. She felt nauseated and had few episodes of vomiting. Pain episode relieved by taking oral analgesiscs. After that patient visited OPD for complaint of pain.USG was ordered for patient which showed sac like structure in GB fossa with three calculi in it and CBD was found to be normal. The histopathology slides of LC reviewed and showed chronic cholecystitis with cholelithiasis. Next MRCP was planned which showed partially distended GB with in GB fossa with multiple areas of signal void suggestive of calculi in GB lumen. A focal out pouching appearing hyperintense on T2 seen anterior to the fundus of GB with defect in anterior wall .On USG correlation wall appears thickened with focal collection seen at the GB fossa anterior to the fundus with defect in the wall likely chronic cholecystitis with contained rupture.CBD was normal. Hb was 11.9g%, TLC 9100/cumm.S Bil 0.5 mg /dl, SGOT-44 U/L SGPT-38U/L, SAP 136U/L all within normal reference range. Patient was planned for relaparoscopy and proceed ,however consents were taken for conversion to open. There were dense adhesions between GB remnant and omentum. Hydro dissection technique was used for separation of adhesions and identifying the cystic duct and cystic artery.Cystic duct and artery clipped separately and GB remnant was taken out .The gross specimen was 2.5 cm in length . Patient was discharged on 2nd postoperative day and in 6 months follow up she is symptom free.

DISCUSSION

While performing open cholecystectomy, the cystic duct is ligated and cut close to the CBD, leaving only a small remnant. In LC the cystic duct is divided closer to the GB to avoid inadvertent CBD injury. Especially during learning curve there is practice of leaving a longer remnant .The practice of accurately locating the junction of GB and CD can be of utmost help.(5,6,7)

Causes of retained GB and cystic duct remnant can be LC, practice of not doing intraoperative cholangiogram routinely and cholecystectomy for acute cholecystitis.(8,9)Repeat cholecystectomy with removal of stones in the GB remnant and cystic duct stones has good post operative results.(5,6,10)After incomplete cholecystectomy the cystic duct remnant and calots triangle are surrounded by inflammation, and makes the laparoscopic procedure difficult.(10)With increased frequency of LC ,which is being performed worldwide ,surgeons experience is also growing very fast. If the GB remnant is quite small then it's possible not to be located with ERCP OR MRCP .In such situations endoscopic USG can play pivotal role.

CONCLUSION

However with the help of great innovations in surgical techniques and instruments and fast growing experience of surgical skills is very promising and even completion cholecystectomy can be safely performed laparoscopically. Technique of hydro dissection plays

crucial role in dealing with dense adhesions and reduces the chances of iatrogenic injuries. USG, MRCP, ERCP, EUS all are part of diagnostic algorithm in evaluation of post cholecystectomy pain. ERCP and ESWL are therapeutic modalities in managing cystic duct and GB remnant stones but completion cholecystectomy is heading towards definitive treatment for managing post cholecystectomy pain.

REFERENCES

1) Sain AH. Laparoscopic cholecystectomy is the current "gold standard"for the treatment of gall stone disease. Ann Surg 1996;224:689-90
2) Zhou PH,Liu FL,Yao LQ.Qin XY.Endoscopic diagnosis and treatment of post cholecystectomy syndrome .Hepatobillary Pancreat Dis Int2003;2:117-120
3) MergenerK,Clavien Pa,Branch MS,Baillie J.A stone in a grossly dialated cystic duct stump:a rare cause of post cholecystectomy pain.Am J Gastroenterol1999;94:229-231
4) Bodvall B,Overgaard B.Cystic duct remnant after cholecystectomy :incidence studied by cholegraphy in 500 cases ,and significance in 103 reoperations .Ann Surg 1966;163:382-390
5) Wals RM,Ponsky JL,Dumot J.Retained gall bladder /cystic duct calculi as a cause of pos tcholecystectomy pain .Surg Endosc 2002;16:981-984
6) Tantia O,Jain M,Khanna S,Sen B.Post cholecystectomy syndrome :role of cystic duct stump and re intervention by laparoscopic surgery.J Minim.Access Surg2008;4:71-75
7) Palanivelu C,Rangrajan M,Jategaonkar PA, Madan KumarMV,Anand NV.Laparoscopic management of remnant cystic duct calculi:a retrospective study.Ann R Coll Surg Engl2009;91:25-29
8) Chowbey PK,BandyopadhyaySk,Sharma A,Khullar R,SoniV,Baijal M.Laparoscopic intervention for residual gall stone disease.Surg Laparosc Endosc Percutan Tech 2003;13:31-35
9) Clemente G,Giuliante F,CadedduF,NuzzoG.Laparoscopic removal of gall bladder remnant and long cystic duct stump.Endoscopy2001;33:814-815
10) Demetriades H,Pramateftakis MG,Kanellos,I,Angelo-poulos S,Mantzoros I,Betsis D.Retained gallbladder remnant after laparoscopic cholecystectomy .J Laparoendosc Adv SurgTech A2008;18:276-279