

PREVENTION OF BILE DUCTS INJURIES DURING LAPAROSCOPIC CHOLECYSTECTOMY

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INTRODUCTION

Laparoscopic cholecystectomy is a surgical procedure in which the gallbladder is removed using special equipment under the control of a laparoscope. The main difference from the classic operation is its low trauma. All manipulations are performed through punctures in the abdominal wall; there is no need for large incisions. The recovery period takes up to 6 days. After one to two weeks, the patient returns to his normal lifestyle.

Materials and methods of the study. In the clinical base of the Department of Faculty and Hospital Surgery of the Fergana Medical Institute of Public Health, which is located in the Department of 1-emergency abdominal surgery of the Fergana branch of the Republican Scientific Center of Emergency Medical Care, 250 laparoscopic cholecystectomies (LCCE) were performed for cholecystitis in the period from 2020 to 2023: 45 (18%) for chronic (CC) and 205 (82%) for acute (AC). Among patients with AC, phlegmonous was found in 131 patients, gangrenous - in 49 patients. In 25 (12.2%) patients, AC was complicated by perivesical infiltrate. Adhesive process in the subhepatic space was observed in 110 patients (44%): 25 with XX, 85 with OX. There were 108 patients over 60 years old (43.2%).

The average duration of the operation was: for XX - 58 min., for OX - 79 min. In most patients, the cystic artery was treated by applying one clip to the proximal part with electrocoagulation of the distal part; in 36 patients (14.4%), the artery was coagulated along its length without clipping.

Results and discussion. Complications developed in 11 patients (4.4%). There were no fatal outcomes. Intraoperative complications occurred in 3 patients (1.2%). Marginal damage to the common bile duct was observed in 1 (0.04%) 72-year-old female patient with phlegmonous AC in the infiltrate during an attempt to isolate the bladder neck, which required switching to an open operation - cholecystectomy with suturing of the common bile duct defect on a T-shaped drainage. This intraoperative injury to the bile duct (IDB) during LSCE was the only one and occurred during the

first operations for AC. Subsequently, we more carefully approached the determination of indications and contraindications for LSCE for AC, based on clinical and ultrasonographic data. In addition, during laparoscopy, manipulations began from the wall of the gallbladder in the area of the neck and Hartmann's pouch, visualized the beginning of the cystic duct and isolated it along the maximum possible length: by performing traction endoclip applied as close as possible to the beginning of the cystic duct. Then we proceeded to careful dissection of the space located behind the duct, first from the lateral, then from the medial side along the contour of the gallbladder until the cystic artery was visualized, which was treated first. After creating a "window" between the cystic duct and the liver, clearly visualizing the cystic duct and the neck of the gallbladder, and the absence of any tubular structures in this area, we clipped the cystic duct and isolated the bladder from the liver bed. With this option, even infiltration in the area of the hepatoduodenal ligament was not an obstacle to the safe performance of LSCE. There were no injuries to the bile ducts.

The overall conversion rate was 6% - 15 observations. One was presented above and in another 5 patients with AC, pronounced cicatricial deformation, adhesions and infiltration in the region of the gallbladder neck with transition to the hepatoduodenal ligament were noted; the operations were successfully completed by the open method.

Conclusions. Thus, based on the analysis of the results of LSCE and the complications that developed, a number of conclusions can be made: LSCE can be performed in any clinical situations, except for those in which differentiation of the most important anatomical structures in the area of the gallbladder neck and hepatoduodenal ligament is difficult; thoroughness in performing all stages of LSCE, especially in AC, and high qualification of the operating surgeon and operating team are extremely important. We believe that a more thorough approach to determining contraindications to LSCE in AC is necessary based on clinical and ultrasonographic data; the diagnostic stage of laparoscopy and initial manipulations in the subhepatic space should provide an answer about the possibility of safely performing LSCE. If there are doubts about safety, the only correct decision is to refuse the laparoscopic version of the operation.

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