

Postcholecystectomy Syndrome and Cholangiography

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Received: December 14, 2017; Published: January 05, 2018

Abstract

Post-cholecystectomy syndrome (PCS) is defined as a complex of heterogeneous symptoms, consisting of upper abdominal pain and dyspepsia, which recur and/or persist after cholecystectomy. PCS occur usually because of incomplete biliary surgery. Could this syndrome be prevented? Intraoperative cholangiography (IOC) an effective way of identifying common bile duct Stones and biliary injury at the time of surgery. This review is summarized the effect of cholangiography on the prevent of PCS.

Keywords: Cholangiography; PCS

Post-cholecystectomy syndrome (PCS) reportedly affects about 10 - 15% of patients [1]. Biliary manifestations of PCS may occur early in the post-operative period, usually because of incomplete surgery (retained calculi in the cystic duct remnant or in the common bile duct) or operative complications, such as bile duct injury and/or bile leakage. Calculi in the common bile duct (CBD) or cystic duct remnant are the most common cause of PCS [1-3].

Common bile duct stones are found in approximately 8% to 12% of all patients who undergo cholecystectomy for symptomatic gallstone disease [1-3]. Can PCS be prevented by performing Intraoperative cholangiography (IOC) continues? IOC continues to be an effective way of identifying common bile duct Stones and biliary injury at the time of surgery.

The use of routine versus selective IOC during laparoscopic or open cholecystectomy remains an area of controversial [1,2]. The routine use of IOC during cholecystectomy; the detection of bile duct stones, tumoral mass, diverticula, defining biliary tree anatomy and the early recognition of iatrogenic common bile duct (CBD) injuries are include. Disadvantage of the routine intraoperative cholangiogram significantly increase operating time and cost. Because of these disadvantages some centers are destined the selectively IOC. As clinic (jaundice, pancreatitis), as radiological (10 mm above the diameter of the common bile duct, exist choledocholithiasis), as laboratorial (high serum bilirubin and enzyme levels) and as operative (expansion of ductus cysticus, palpable stone in the choledocus) are indication for selective IOC. Whereas; Of the preoperative predictive factors investigated, the most specific for CBD stone detection on IOC was bilirubin at 89% [3-6]. The most sensitive was preoperative MRCP at 77% [3]. So MRCP is not an alternative to IOC. But MRCP techniques are reliable for identifying biliary causes of PCS.

There are studies that suggest that the routine IOC increases recognition of CBD injury at the time of the operation, which in turn influences the success of repair and long-term outcomes [4-7]. There are also studies that suggest that routine employment of IOC does not lead to a reduced risk of CBD injury or better outcomes [5-10].

As a result, at present there is still no alternative method to IOC to detect the injuries of the gallbladder pathways, tumor and bile duct stones. If IOC made during cholecystectomy, can prevent biliary stricture and identified residual stones of choledocus. So the most common cause of PCS could be avoid.

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Volume 5 Issue 1 January 2018

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