Surgical management of acute cholecystitis complicated by hyperbilirubinemia

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Endoscopic Retrograde Cholangio Pancreatography (ERCP) is widely performed as an initial surgical treatment for patients with acute cholecystitis complicated by hyperbilirubinemia. This procedure carries a significant risk of complications, and needs to be performed by a highly experienced professional. The objective of our study was to evaluate the effectiveness of less dangerous, in our view, surgical approach to this clinical problem. First, we performed laparoscopic cholecystectomy on two hundred and forty-eight patients with acute cholecystitis complicated by hyperbilirubinemia followed by T-tube cholangiography on third postoperative day (1996-2009). Signs of compression of Common Bile Duct (CBD) by inflamed and swollen ligaments were seen intraoperatively in 68 patients (67.8%). Gallstones under 1 cm and CBD around 1 cm were found in 44 patients (17.7%). Gallstones over 1 cm and CBD of 1.5 cm were found in 11 patients (4.4%). In cases where gallstones were found, they were removed by ERCP (less than 1 cm) or by classic methods (greater than 1 cm). If no biliary obstruction were seen, drainage was removed in the following two days. Other causes of hyperbilirubinemia (pancreatitis, strictures, etc.) were found in 25 patients (10%). Only two of them required surgical attention. T-tube cholangiography, performed on third day after cholecystectomy, showed that 184 patients (74.1%) had no biliary flow obstruction and normal bilirubin levels; as a result ERCP was not indicated. Taking this into account, we recommend first to perform cholecystectomy, with placement of external drainage and perform T-tube cholangiography on the third postoperative day, followed by ERCP if indicated.

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