ABSTRACT: We present laparoscopic cholecystectomy in a 72 years old postmenopausal obese female weighing 98 kgs. The patient presented with dyspepsia. The USG of abdomen showed an acute inflamed gallbladder with multiple huge stones, distended GB with wall thickness of 7 mm and mucocele. We performed laparoscopic cholecystectomy, leaving the thick adherent posterior wall there and removed all the stones by conventional four port technique. The postoperative period remained uneventful and the patient was discharged next day.

KEYWORDS: Cholecystitis, mucocele, Phrygian cap, laparoscopy.

INTRODUCTION: Gallstones are very common in humans. By the age of 75, about 35% of women and 20% of men would have developed gallstones. Death caused by gallstones is uncommon and accounts for roughly 5000 of the 2.2 million deaths per year in the United States. In patients in the West, the majority are either cholesterol or mixed cholesterol/calcium bilirubin stones. Most patients with gallstones are asymptomatic and only about 10% will have developed symptoms five years after discovery. In a functioning gallbladder, most of the gallstones are cholesterol stones. Gallstone disease is a relatively common problem in Jammu and Kashmir as in the North of India as well. It is estimated that more than sixty percent of these patients have cholesterol stones. The first open cholecystectomy was carried out in 1882 by Carl Von Lagenbuch. In 1985, Prof. Erich Muhe of Boblingen, Germany had carried out the first laparoscopic cholecystectomy. He presented his technique at the Congress of the German Surgical Society. Unfortunately, his technique was not appreciated by his colleagues and did not become popular. His work was not realized until 1999, when he was recognized by SAGES for having performed the first laparoscopic cholecystectomy. Laparoscopic intervention in cases of acute cholecystitis is a recent one. Although laparoscopic cholecystectomy has been accepted as the gold standard for symptomatic cholelithiasis, laparoscopic cholecystectomy in acute cholecystitis is still considered a relative contraindication, particularly for the beginners.

CASE REPORT: We performed laparoscopic cholecystectomy in a 72 years old postmenopausal obese female weighing 98 kgs. The patient had hypertension but under control with medications. The USG of abdomen showed an acute inflamed gallbladder with multiple huge stones, distended GB with wall thickness of 7 mm and mucocele. Laparoscopic cholecystectomy was performed by conventional four port technique. Pneumoperitoneum was introduced by Verress needle through the umbilicus. A 10 mm camera port was made at umbilicus and another 10 mm working port was made at the epigastrium. Two 5 mm ports were made, one at the mid clavicular line 2 cms below the costal margin (working port) and other at right iliac fossa (retraction port). There was distended GB, thick walled with one big stone impacted at the neck of GB and mucocele. The GB had a Phrygian cap at its fundus which is one of the common congenital anomalies. We introduced a gauze piece for dissection at the Calot’s triangle.
Fig 1. GB with phyrigian cap, thick walled with mucocele. Fig 2. GB decompressed by the sucker

Fig 3. The gauze dissection done at the Calot’s triangle. Fig 4. The cystic duct clipped and being cut.

The gauge dissection was done to delineate the cystic duct. The duct was clipped and cut. The vessel was buzzed with monopolar cautery. We did a hook dissection and kept the posterior wall there which was adherent to the posterior wall of liver. The stones were removed enmass into the polythene bag. The thick walled GB was removed through the epigastric port. The posterior wall of GB was fulgrated with monopolar cautery and hemostasis was achieved. Suction and irrigation was done and the Romovac drain was put in the subhepatic area.

Fig 5. The thick posterior wall left behind the stones protruding out. Fig 6. The big stone impacted at the neck being bagged. Fig 7. The posterior thick wall adherent to inferior surface of liver being fulgrated.

DISCUSSION: Laparoscopic management of acute cholecystitis is safe and effective and enjoys the same benefits as compared to those undergoing elective laparoscopic cholecystectomy. The pain is significantly less and early postoperative recovery has been noticed in different series. Hospital stay is significantly less. The laparoscopic intervention in acute cholecystitis needs experience and is acceptable in experienced hands. The management of acute biliary disease may be improved in patients, if operated by surgeons.
experienced in laparoscopic in biliary surgery and those who perform lapchole regularly. In recent times lapchole is being increasingly performed for acute cholecystitis and is indicated in all the variants of acute complications of gallbladder diseases. Various studies have shown that laparoscopic treatment offers significant advantages compared to open approach, therefore acute cholecystitis alone should not preclude an attempt at laparoscopic cholecystectomy. Management of acute cholecystitis by laparoscopy is difficult and a challenging task and various factors determine the outcome of the procedure. Due to various alterations in the ductal and capsular anatomy, lapchole in case of gallbladder inflammation is associated with increased incidence of complications. However with experience and good technique, laparoscopic cholecystectomy has been shown to provide good results in terms of patient outcome and morbidity. The laparoscopic approach is safe and feasible treatment. Although the morbidity is low, there might be an increased risk of conversion and complications. We believe that early laparoscopic cholecystectomy in the acute stage is now the preferred treatment.

REFERENCES:


Conflict of Interest: None

Author Information:
Mushtaq Chalkoo, MBBS, MS, FMAS
Lecturer and Consultant Laparoscopic and Minimal Access Surgeon
Department of Surgery
SMHS Hospital,
Srinagar, Kashmir, India
Pin: 190001
Email: mushtaq_chalkoo@rediffmail.com
Mobile No: 09419032292