Routine Intra-Operative Cholangiography for Safe Laparoscopic Cholecystectomy and Single Stage Laparoscopic Choledocholithotomy

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Citation

Abstract
Background: While laparoscopic cholecystectomy is widely accepted for therapy of cholecystolithiasis, controversy still exists concerning the routine use of intra-operative cholangiography (IOC) during laparoscopic cholecystectomy (LC) and its role in the management of common bile duct stones at the same procedure, whether they are discovered accidentally or expected at a planned single-stage procedure if respective experience is available.

Methods: During laparoscopic cholecystectomy, a cholangiography via the cystic duct is routinely performed. If bile duct stones are detected, they are retrieved via the cystic duct or via incision of the common bile duct by insertion of a Fogarty catheter or Dormia basket. Exclusion criteria against simultaneous laparoscopic management include suspicion of malignancy, severe pancreatitis or cholangitis.

Results: From July 2005 to June 2007, 172 patients primarily underwent laparoscopic cholecystectomy, IOC was successful in 157 (91.2%). Bile duct stones were found in 26 patients (15.1%), dilated ducts without stones in 6 patients (3.4%), and anatomic variations in 3 patients (1.7%). Retrieval was performed via cystic duct and common bile duct in 15 and 11 cases, respectively, with complete removal. There were 2 (1.1%) minor injuries of the bile duct, which were identified with IOC and repaired at the time of cholecystectomy without any consequences for the patients, while in 3 patients (1.7%) cholecystography was done for difficult identification of cystic duct and acute inflamed gall bladder.

Conclusions: Routine intra-operative cholangiography is feasible, provides valuable information about the anatomy of the biliary tract and might aid in the prevention of bile duct injuries, thereby improving the safety of laparoscopic cholecystectomy. When indications are correct and surgical expertise is available, simultaneous laparoscopic management of common bile duct stones represents a safe and minimally invasive alternative to a two-stage procedure approach.

INTRODUCTION
During the past decade, laparoscopic cholecystectomy (LC) rapidly developed to become the standard procedure for management of symptomatic cholecystolithiasis 1. However, controversy still exists concerning the routine use of intra-operative cholangiography (IOC), and the optimal therapy for simultaneous common bile duct (CBD) stones 2. This will continue for the coming years as many factors like surgical expertise and the cost of instruments used add to the controversy regarding the proper role of IOC for patients undergoing LC, especially in identifying the anatomy and the abnormalities of the biliary tract and thus reducing the rate of bile duct injuries 3. LC also detects asymptomatic bile duct stones; the frequency of simultaneous presence of bile duct stones varies from 8 to 19%, increasing with age 3. Before the introduction of endoscopic retrograde cholangiopancreatography (ERCP) with papillotomy and laparoscopic cholecystectomy (LC), open common bile duct exploration was considered the standard procedure 6.

At present, including the above two minimally invasive techniques (ERCP with papillotomy and LC) three competing therapeutic concepts emerge 7,8.

1. Preoperative, intra-operative, and/or postoperative endoscopic treatment of common bile duct stones followed by laparoscopic (or open) cholecystectomy.
2. Primary laparoscopic CBD exploration during laparoscopic cholecystectomy.
3. Open cholecystectomy and simultaneous treatment...
of CBD stones.

We retrospectively reviewed the results of 172 consecutive LCs where IOC was performed routinely with laparoscopic management of CBD stones, when detected, as a single-stage procedure, achieved either through the cystic duct or by choledochotomy. Our results are presented, discussed, and compared to data in the literature with emphasis on the role of routine IOC.

MATERIAL AND METHODS

Between July 2005 and June 2007, 172 patients who presented for elective or acute laparoscopic cholecystectomy were studied. There were 68 men (40%) and 104 women (60%) with a mean age of 49±18 years (Table 1). Intraoperative cholangiography was attempted routinely in all patients either through cannulation of the cystic duct in 154 patients (89.5%) or through direct puncture of gall bladder (cholecystography) step by step in 3 patients (1.7%) to identify the cystic duct in acute or difficult cases.

Table 1: Patient demographics and operative times

<table>
<thead>
<tr>
<th>No.</th>
<th>Characteristics</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Age (yr.)</td>
<td>49 (14-97)*</td>
</tr>
<tr>
<td>2</td>
<td>Female/male</td>
<td>104/68</td>
</tr>
<tr>
<td>3</td>
<td>Previous abdominal surgeries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Lap. Nissen fundoplication</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>- Umbilical hernia repair</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>- Appendectomy</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>Mean operative time for LC (min.)</td>
<td>45.5 (25-180)*</td>
</tr>
<tr>
<td>5</td>
<td>Additional operative time for IOC (min.)</td>
<td>12 (7-45)*</td>
</tr>
<tr>
<td>6</td>
<td>Mean hospital stay (days)</td>
<td>3±2</td>
</tr>
</tbody>
</table>

*M, Median (range), *Mean (range), LC: laparoscopic cholecystectomy, IOC: intraoperative cholangiography

Preoperative evaluation included abdominal ultrasonography, routine laboratory tests and liver function tests (LFTs). Contraindications for this procedure included suspicion of malignancy, severe pancreatitis and/or cholangitis, and unfitness for anesthesia. Such patients were primarily selected for further diagnostic magnetic resonance cholangiopancreatography (MRCP) or endoscopic retrograde cholangiopancreatography (ERCP) with optional papillotomy.

OPERATIVE PROCEDURE

To perform a static IOC, after dissection of the cystic artery and duct, a titanium clip is applied to the cystic duct close to the gall bladder infundibulum. Then a 5-Fr ureteral catheter, which is passed into the abdominal cavity by a grasping forceps (5mm, Storz Company, Tuttingen, Germany) (Fig. 1 A) or enters the intra-abdominal cavity next to the trocar (sub-xiphoid trocar), is pushed into the cystic duct through a small transverse incision on the anterior surface of the cystic duct made by scissors, until its distal hole passes into the lumen.

Figure 1

Figure 1: Instruments used in operative cholangiogram: (A) grasping forceps. (B) Fogarty catheter.

The catheter is fixed in its place by a titanium clip or by the grasping forceps. Before administration of the contrast dye, 3-5ml of saline are flushed into the lumen to examine the position of the catheter, its fixation and the patency of the lumen. If no water leaks, the grasper at the site of the costal margin is pulled to prevent its interference in the IOC. Following administration of 2ml of contrast dye (Ibimiro) via a syringe into the catheter, a supine IOC is obtained with a portable unit to visualize the distal CBD and Oddi’s sphincter. Then the patient is placed in the Trendelenburg position, and additional 3ml of contrast dye are administered to visualize the proximal CBD, right and left hepatic ducts and the junction (Fig. 2).
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**Figure 3**
Figure 2A, B, C, D, E, F: A: Incision on the anterior surface of the cystic duct. The catheter fixed in the cystic duct by titanium clip with injection of contrast media. Graph showing a dilated CBD with opaque shadow (stone). Insertion of a Fogarty catheter in the cystic duct and passing to the CBD to extract the stone. Graph showing the CBD cleared from stones and passage of dye to the duodenum. Clipping of the cystic duct opening.

![Figure 3 images](image1)

In a severely inflamed gall bladder with difficult dissection, the catheter is passed through an apparent part of the gall bladder and step by step moved forward to the cystic duct after clarifying of the cystic duct by position and length in relation to the CBD (Fig. 3A, B, C, D).

**Figure 4**
Figure 3A, B, C, D: Cholecystography for acutely inflamed gall bladder. Aspiration of gall bladder content. Graph showing the catheter and contrast dye in the gall bladder; the cystic duct appears clearly and with good length. Catheter moved to the cystic duct and IOC showing proximal and distal CBD as well as pancreatic duct with free passage of dye to the duodenum.

![Figure 4 images](image2)

Cholangiograms were routinely evaluated during the operation, focusing on some findings:

- Anatomic variations (Fig. 4).
- Passage of contrast media into duodenum.
- CBD diameter and stones.

Visualization of distal and proximal CBD as well as of the hepatic ducts.
Figure 5
Figure 4: Picture of a cholangiogram showing how it clearly demonstrates the anatomy. In this particular case, an aberrant right hepatic duct is demonstrated.

If CBD stones are detected, primary management via cystic duct is intended. Under X-ray guidance, a Dormia basket or Fogarty catheter (Fig.1B) is introduced and small stones measuring <5-6mm in diameter are extracted or advanced through the papilla into the duodenum. We do not perform balloon dilatation of the cystic duct and also we regularly use a Glucagon 1mg IV flush with warm saline. If transcystic retrieval cannot be performed because of the size or position if the stones (i.e., common hepatic duct), removal is conducted via longitudinal CBD incision. A T-tube or double-balloon catheter is introduced via the common bile duct incision and the incision is closed by running suture (absorbable Vicryl suture 3/0). Following transcystic management including a final cholangiography proving absence of stones, the cystic stump is closed using endoclips without insertion of a bile duct drainage tube. A drainage tube is routinely inserted into the subhepatic operative field after LC (with or without bile duct management). A four-trocar technique is sufficient in most cases (10-mm supraumbilical, 10-mm midline epigastric, two 5-mm ports in the right upper quadrant of the abdomen) Four to six percent of our procedures have been conducted using three and five trocars, respectively.

In our cases, IOC with photo documentation was kept with the patient's record. The first follow-up visit was one week postoperatively; then, follow-up occurs monthly and then every 3 months.

RESULTS
Between July 2005 and June 2007, 172 cholecystectomies were performed due to bile stone disease, of which 170 (93%) were conducted laparoscopically. Two additional conventional procedures were done within laparotomies based on other indications. During the same period simultaneous bile duct stones were detected in 26 individuals (15.1%). In 11 of these patients (6.3% of all cholecystectomies) diagnosis was attained only during operation. Twenty-four patients underwent primary laparoscopic management.

Transcystic management was performed in 14 patients (8.1%), common bile duct incision in 9 individuals (5.3%); complete removal of CBD stones was achieved in 23 patients (13.4%). In one patient (0.58%), residual concrements were removed by EPT (endoscopic papillotomy) intraoperatively. In two cases (1.1%), large stones were impacted and retrieved via laparotomy. So, using this technique, ERCP/EPT was avoided in 23 patients (Table 2).
Mean operation time including cholecystectomy was 140 min. (range: 55 to 250 min.). Peri- and postoperative complications were observed in 1.1% of patients (n=172). Two patients were re-operated (one laparotomy and one relaparoscopy for treatment of severe bleeding and bilioma formation, respectively). One 64-year-old patient died as a result of a cardiac complication on the 8th postoperative day (0.5%).

DISCUSSION

Controversy still exists concerning the routine use of intra-operative cholangiography (RIOC). But considering the various and valuable information obtained by IOC like unexpected biliary anatomy and the incidence of missed asymptomatic ductal stones, RIOC is cost-effective and is recommended in all LCs.9,10

Asymptomatic ductal stone means that the patient has no history, sonographic evidence, or laboratory tests indicating the presence of ductal obstruction.11 A normal cholangiogram, routinely performed, almost always means a clear bile duct and so it can prevent an unnecessary postoperative ERCP and its potential complications for the symptoms that can be attributed to retained ductal stones.12-13,14,15

Several other studies have shown that RIOC can detect significantly more biliary injuries as well as unexpected biliary anatomy of potential surgical relevance.16 During the 1990s, a higher rate of iatrogenic biliary tract injuries was reported, and this was attributed to the learning curve for LC. In a review of patients, who were referred to their tertiary center with iatrogenic biliary tract injuries during a 7-year period, Stewart and Way identified the two most important reasons for ductal injury during LC as (a) false identification of CBD as the cystic duct and (b) aggressive efforts to stop bleeding. They outlined 14 principles to avoid nearly all ductal injuries, the two most crucial of which are the liberal use of IOC and to cautiously interpret the lack of opacification of the proximal CBD as a sign of its closure.21

There are also arguments that RIOC wastes time and money. It has been estimated that if one severe bile duct injury is prevented in every 1,000 LCs, the cost of all “unnecessary” IOCs will be saved. A cost-effectiveness analysis estimated that RIOC would cost $100 more per LC. However, it would save $390,000 per death avoided and $87,143 per CBD injury avoided. The extra charge for a static IOC during LC in our center in Ain Shams University Hospital/Egypt is approximately $55 and in Landeskrankenhaus Bregenz/Austria is approximately 85 Euro including radiology department fees (including the fee for a portable radiological device per single use, radiology technician, two cassettes, and development of two radiological films) and operating room instruments used (one ureteral catheter, one angiocath, and 10 ml of contrast dye).17,18,19,24

Bile duct stones are detected more frequently when IOC is employed routinely rather than selectively and management of these unexpected ductal stones found during LC in the era of laparoscopic surgery is still controversial. Before the establishment of new endoscopic techniques (ERCP/endoscopic papillotomy – “EPT”) and laparoscopy, open surgery represented the gold standard for management of choledocholithiasis.2,21 Nowadays, preoperative ERCP/EPT followed by LC is considered to be the concept of choice for most surgeons. This two-step procedure is generally accepted because of its significant lower complication and mortality rate when compared to open bile duct surgery.11,18,27,28 In contrast, a Germany-wide survey

Table 2: Operative Characteristics

<table>
<thead>
<tr>
<th>Operative Characteristics</th>
<th>No. of Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) Successful intra-operative Cholangiography:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A - Bile duct stones</td>
<td>157</td>
<td>91.2</td>
</tr>
<tr>
<td>* Retrieval was performed via cystic duct</td>
<td>26</td>
<td>15.1</td>
</tr>
<tr>
<td>* Retrieval via common bile duct</td>
<td>15</td>
<td>8.7</td>
</tr>
<tr>
<td>* Retrieval via laparotomy</td>
<td>9</td>
<td>5.1</td>
</tr>
<tr>
<td>B - Dilated ducts without stones</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>C - Anatomic variations (aberrant right hepatic duct)</td>
<td>6</td>
<td>3.4</td>
</tr>
<tr>
<td>D - Stone in the cystic duct</td>
<td>3</td>
<td>1.7</td>
</tr>
<tr>
<td>E - Cholecystography (dense adhesions at Calot’s)</td>
<td>5</td>
<td>2.9</td>
</tr>
<tr>
<td>F - No difficulty in cannulation of cystic duct &amp; no abnormality</td>
<td>129</td>
<td>75</td>
</tr>
<tr>
<td><strong>2) Failed intra-operative Cholangiography:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A - Difficult cannulation of cystic duct</td>
<td>15</td>
<td>8.7</td>
</tr>
<tr>
<td>B - Conversion to open cholecystectomy</td>
<td>3</td>
<td>1.7</td>
</tr>
<tr>
<td>* Dense adhesions at Calot’s (severely inflamed gallbladder or fibrosis of Calot’s triangle)</td>
<td>12</td>
<td>6.9</td>
</tr>
<tr>
<td>* Inability to achieve working space due to dense intra-abdominal adhesions</td>
<td>3</td>
<td>1.7</td>
</tr>
<tr>
<td>* Impacted ductal stones</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>* Severe bleeding</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>* Instrumental, technical &amp; radiographer variables</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>0.58</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1.1</td>
</tr>
</tbody>
</table>
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reports a surprisingly high rate for initial open bile duct management of ~11.6%\textsuperscript{15}. In 74.4% of institutions, initial ERCP/EPT and subsequent LC were considered as first choice treatment, if bile duct stones were diagnosed prior to operation; 58.4% decided for endoscopic papillotomy when stones were detected intraoperatively\textsuperscript{20\textsuperscript{22\textsuperscript{23\textsuperscript{30}}.}

Although ERCP is quite efficient in the management of ductal stones, it has a morbidity rate of 7-11% and a mortality of <1%, especially if accompanied by endoscopic sphincterotomy (ES) and thus postoperative ERCP can be reserved for those who become symptomatic during the follow-up period\textsuperscript{24}.

Because of increasing surgical experience, technical improvements in laparoscopy, and general acceptance of LC as a standard procedure, laparoscopic CBD exploration should gain wider application. Intra-operative cholangiography is absolutely necessary for laparoscopic bile duct surgery and is therefore routinely performed in our series. Though it was considered a standard procedure during the time of open cholecystectomy, at present, intraoperative cholangiography is routinely performed in only 6% and selectively in 49% of institutions\textsuperscript{15}. This procedure provides safe orientation in the presence of difficult anatomy and lowers the risk and rate of undetected iatrogenic lesions of the common bile duct\textsuperscript{25}. In addition, it improves the prognosis of bile duct lesions by facilitating intra-operative diagnosis and repair\textsuperscript{3}. Furthermore, intraoperative cholangiography requires detailed identification of the cystic duct, thus enabling the surgeon to assess anatomical variations\textsuperscript{18}.

When routine and surgical skills are available, additional operation time and costs are kept low and prove to be justified by reducing intra-operative complications\textsuperscript{12}. Taking into account a complication rate varying between 3.4% and 11.7%, a long-term time morbidity of up to 15% and mortality rate of 0.9% for endoscopic papillotomy (EPT) alone without cholecystectomy, so strong efforts for patient health ensuring simultaneous management via the cystic duct are understandable\textsuperscript{31\textsuperscript{32\textsuperscript{33\textsuperscript{34}}.}

Controversy still exists concerning impaired function of the papilla following EPT: Soehendra et al.\textsuperscript{33} report absence of papilla function impairment. In contrast, other groups report reflux of duodenal secretion into bile ducts and presence of bacteria in the bile duct system in 70% of cases\textsuperscript{36}, and significant biliary symptomatology in 15% of patients\textsuperscript{35\textsuperscript{37\textsuperscript{38}}.}

Tranter and Thompson reported a late development of bile duct cancer in up to two per cent of patients following EPT, possibly based on the chronic mucosal inflammation\textsuperscript{41}. In contrast, laparoscopic CBD exploration provides anatomical and functional integrity of the papilla\textsuperscript{40}.

The reported results of laparoscopic CBD exploration are comparable to data obtained after a two-stage procedure (success rate between 82% and 95%), show at least identical but rather improved safety for the patient, and partial reduction of costs\textsuperscript{37\textsuperscript{39\textsuperscript{40\textsuperscript{43}}}. In a prospective randomized trial including 40 patients per treatment arm, Rhodes et al.\textsuperscript{41} show similar success rates and operation times and significant shorter hospitalization time for individuals treated by laparoscopy. Cuschieri et al.\textsuperscript{15} reports on a prospective randomized multicenter trial showing similar success and complication rates and a significant reduction of hospital stay for the single-stage management of CBD stones. Furthermore, it is shown that particularly patients with ASA stage I and II benefit from simultaneous laparoscopic therapy. According to a recent publication, laparoscopic CBD exploration can also be conducted safely with a low complication rate in older patients\textsuperscript{19}.

Stress and morbidity are equal to LC without CBD exploration. Similarly, morbidity following choledochotomy is comparable to data obtained after a two-stage procedure and lower, when compared to open surgery\textsuperscript{42\textsuperscript{43\textsuperscript{46}}. However, an advantageous impact on shorter hospital stay is not observed.

In our series of 26 CBD explorations, stones were detected only intraoperatively in 42%. This represents 6.3% of all cholecystectomies. Because of routine intra-operative cholangiography and simultaneous CBD exploration in positive cases, negative preoperative endoscopies are avoided and the requirement for endoscopic retrieval of remaining stones is reduced to a minimum (in our series, 0.58%). Furthermore, using this approach, ERCP and EPT, as well as procedure-associated risks, could be avoided in 23 patients (92%).

According to the recommendations of international surgical societies\textsuperscript{26\textsuperscript{30}} the decision for preoperative EPT or simultaneous laparoscopic management of CBD stones is left to the surgeon, depending on his experience in laparoscopy and the availability of technical equipment\textsuperscript{30}.
CONCLUSION

RIOC is a safe, accurate, quick, and cost-effective method for the detection of bile duct anatomy and stones. A highly disciplined performance of RIOC, especially in the hands of an experienced laparoscopic surgeon, can well minimize the potentially debilitating and hazardous complications of bile duct injury.

In terms of outcome and safety, laparoscopic management of cystic and common bile duct stones must be considered equal to the common two-stage procedure with preoperative endoscopic papillotomy (EPT). Transcystic management, notably, does not stress the patient more than cholecystectomy alone and should, therefore, always be attempted. Based on our experience, the complication rate of laparoscopic common bile duct exploration and cholecystectomy equals data reported for ERCP and EPT without cholecystectomy. In addition, the laparoscopic approach provides preservation of the papilla. Therefore, we are convinced that this single-stage procedure represents a profound development in the therapy of choledocholithiasis.

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