Editorial

E.H.

Farthmann

Freiburg i.Br.

Increasing numbers of laparoscopic cholecystectomies have focused interest on the management of the common bile duct injuries, as illustrated in this issue [1]. The rate of bile duct injury following laparoscopic cholecystectomies has declined to a range of from 0.2 to 0.5%, thus approximating the percentage of bile leak after open cholecystectomy [2-4]. The main risk factors for this complication are inexperience of the surgeon, anatomic variations or altered tissue due to inflammation. Intraoperative cholangiography may be helpful in detecting an imminent or present complication. Postoperative ERCP is the method of choice to prove a biliary leakage. In a few cases, where endoscopic cholangiography cannot be performed, percutaneous transhepatic visualization should be chosen to exclude biliary leakage.

Insufficient closure of the cystic stump can best be treated by endoscopic sphincterotomy and placement of an endoprosthesis. Following complete dissection of the common bile duct a Roux-en-Y hepaticojejunostomy needs to be performed. With this kind of reconstruction, the rate of late complications, like stenosis, is significantly lower than with termino-terminal anastomosis of the common bile duct. Some surgeons tend to perform a Roux-en-Y hepaticojejunostomy not only after dissection but also after injury with leakage of the common bile duct [5]. European centers mostly insert prostheses as the treatment of choice for management of common bile duct injuries in analogy to cystic stump insufficiencies.

The treatment of stenoses of the common bile duct as sequelae of bile duct injuries includes balloon dilatation and insertion of an endoprosthesis. In most cases we are able to conclude this treatment successfully after 12 months. In contrast to a significantly lower morbidity and mortality there may be a higher incidence of stenosis in the long-term follow-up compared with the operative procedure.

The hesitation of our American colleagues concerning interventional procedures may be based on the fact that the patient needs to be transferred for endoscopic therapy. Our claims that a specialist performing a certain technique should be capable of treating its inherent complications points out the necessity of the availability of endoscopic expertise in specialized surgical departments.

References 1 Luffer JM, Gr M, Schweizer W, Bchler

MW: Endoscopic Management of Iatrogenic Biliary Fistulas. Dig Surg 1995;12:348-351.

Deziel DJ, Millikan KW, Economou SG, Doo-las A, Ko ST, Airan MC: Complications of laparoscopic cholecystectomy: A national survey of 4,292 hospitals and an analysis of 77,604 cases. Am J Surg 1993;165:9-14.

Morgenstern L, Wong L, Berci G: Twelve hundred open cholecystectomies before the laparoscopic era: A standard for comparison. Arch Surg 1992;127:400-403.

Strasberg SM, Hertl M, Soper NJ: An analysis of the problem of biliary injury during laparoscopic cholecystectomy. *J Am Coll Surg* 1995; 180:101-125.

Lee VS, Chari RS, Cucchiaro G, Meyers WC: Complications of laparoscopic cholecystectomy. *Am J Surg* 1993;165:527-532.

© 1996 S. Karger AG, Basel