Introduction

B. Jeppsson

Department of Surgery, Malmö University Hospital, Malmö, Sweden

Introductory Lecture

Hepatic Surgery

Hepatic surgery is in general safe. Several studies have been published both in Europe and the USA with up to 1,000 hepatectomies giving a mortality rate of less than 5%. Morbidity is still high and up to 30–40% in some materials. Most complications relate to intra- or postoperative bleeding and infectious conditions with sepsis or cholangitis. Other complications include lesions in the biliary tree as well as thromboembolism and pulmonary difficulties. Some risk factors are associated with a higher mortality and morbidity rate and it is important to identify these. They include intraoperative blood transfusion, HIV-positive patients, presence of cirrhosis and emergency operation. One of these case presentations will illustrate this.

Biliary Surgery

The most frequent serious complication in modern biliary surgery and especially cholecystectomy is injury to the common bile duct. It is still not settled if a laparoscopic procedure will in itself infer an increased risk for bile duct injuries. The information from different clinical studies is still inconclusive but may indicate that the laparoscopic procedure by itself may carry a slightly increased risk of bile duct injuries compared to open surgery. The incidence varies in different nations but we should, if

properly performed, not accept a higher risk than at open surgery. The most important aspect in this instance is what will be addressed here, i.e. intraoperative identification and proper repair but most importantly, we must focus on prevention. There are some conceptions or rather misconceptions regarding bile duct injuries in laparoscopic surgery. One is that these injuries mostly occur when surgeons under training are performing the procedure. This is not true. Many studies verify that the injuries occur just as frequently in the hands of qualified surgeons. The injuries most frequently occur in instances where there is a normal anatomy. Furthermore, most injuries occur in the distal biliary tree and most injuries are detected postoperatively. There are still arguments on whether intraoperative cholangiography may reduce the likelihood for injuries. This question has not been settled yet, but if intraoperative cholangiography is performed it must be performed in a correct way, i.e. under fluoroscopic guidance and that the operation is halted until the anatomic situation is completely clear. Another advantage of intraoperative cholangiography may be that intraoperative injuries may be detected immediately. In the following case presentation we will discuss intraoperative detection of injuries, the postoperative identification and the proper management of different repair of bile duct injuries as well as their associated complications. But most important, we must address the issue of prevention.

KARGER

Fax +41 61 306 12 34
E-Mail karger@karger.ch
www.karger.com

© 2002 S. Karger AG, Basel
0253-4886/02/0192-0105\$18.50/0

Accessible online at:
www.karger.com/journals/dsu

Bengt Jeppsson, MD
Department of Surgery, Malmö University Hospital, Allmänna Sjukhuset
S-205 02 Malmö (Sweden)
Tel. +46 40 333760, Fax +46 40 927877
E-Mail bengt.jeppsson@kir.mas.lu.se