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**LAPAROSCOPIC CHOLECYSTECTOMY: Experience of the Department of Visceral Surgery wing 3 at the Ibn Rochd University Hospital of Casablanca and the Faculty of Medicine and Pharmacy of Casablanca, Morocco
(About 1200 cases over a 5-year period)**

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ABSTRACT

Since 1991, laparoscopic cholecystectomy has become the gold standard for the treatment of symptomatic biliary lithiasis. Nevertheless, a number of procedures are very difficult to perform in laparoscopy. It is for this reason that systems have been developed which facilitate gesture and make laparoscopic gestures easier to perform. It is a retrospective study of 1200 cases of cholecystectomies collected at the department of visceral surgery III of the CHU of Casablanca over a period of 06 years (2010-2015). The aim of this work is to evaluate the experience of the service on the practice of laparoscopic cholecystectomy, while underlining the difficulties encountered in the different indications.

Keywords : Biliary lithiasis - Cholecystectomy - Laparoscopy - Conversion.

INTRODUCTION

The laparoscopic pathway has rapidly established itself as the primary referral route for cholecystectomy for 25 years. This technique consists in creating a working space by blowing carbon dioxide into the peritoneal cavity in order to perform a surgical procedure using instruments introduced by small incisions under the visual control of an endoscope. This technique has many advantages in comparison with open surgery: Duration of hospital stay and reduced work stoppage, complications of the rarer abdominal walls. However, laparoscopic technique is associated with a non-negligible risk of complications. Thus, the risk of injuries to the biliary ducts and pedicular vessels appears to be increased with laparoscopic technique. Their treatment is sometimes difficult, requiring the transfer to a specialized center in order to optimize the management.

MATERIALS AND METHOD

This is a retrospective study of 1,200 cases of cholecystectomy collected in the department of visceral surgery III of the CHU of Casablanca over a period of 06 years (2010-2015). The average laparoscopic surgical activity was 200 interventions per year. The predominance was feminine (90.1%), with a sex ratio of 0.11. The medical history was dominated by high blood pressure

(18.17%) and diabetes (10.33%), the surgical history was dominated by Caesarean section (8.83%). Laparoscopic cholecystectomy was performed without incidents in 95.16% of cases. Conversion was performed in 55 patients (4.58%). Cholecystitis was the leading cause of conversion (56.36%), followed by bleeding (9.09%), primary bile duct injury (7.27%), and dilation of the primary bile duct (5.45%). A hepatic drain was placed in 640 patients, ie 53.3%. The results were simple in 97% of the cases. Postoperative complications were dominated by decompensation of an underlying condition (51.6%). The total hospital stay was 4 days. Late sequels were simple in 99.75% of the cases. 3 patients had residual lithiasis of the main bile duct.

RESULT AND DISCUSSION

The first cholecystectomy was performed in 1882 by a German surgeon, Carl Johann August Langenbuch. Then, it took a century (1987) to witness the advent of laparoscopic cholecystectomy [15]. The laparoscopic pathway was then rapidly established as the first reference route for cholecystectomy [19]. The comparative study of our series with those published in the Moroccan and foreign literature shows a concordance in epidemiological, clinical, echographic, operative and complication results. Thus, laparoscopic cholecystectomy represents a model of simple postoperative rehabilitation programs [5, 7, 20]: reduction of postoperative pain, early emergence, early replenishment, discretion of scars, Parietal complications and a reduction in the length of hospital stay. The laparoscopy also has some advantages over open surgery for the surgeon [2,8,10]: The quality of vision obtained on the screen puts comfort in the surgeon and the aid, the peritoneal cavity can be explored From the diaphragmatic domes to the Douglas' cul-de-sac, the view on the hepatic pedicle and especially on its posterior surface is excellent. However, the absence of manual palpation may be troublesome. Although cholecystectomy is a frequent procedure of simple sequelae, rare complications can occur, mainly due to the potential severity of iatrogenic sores in the biliary tract [11,12,17]. These can be minimized by respecting the technical rules of cholecystectomy. However, rapid and appropriate care, accurate and honest information and easy recourse to expert centers improve the prognosis for the patient [3,11,14]. The incidence of the risk of vascular lesions was evaluated at 0.06% and appears to decrease with the surgical experience [6]. The parietal complications have seen their frequency diminish by laparoscopy without removing them [11]: Hemorrhage, abscess, event. Complications related to laparoscopy are represented by visceral (duodenal, colic) perforations, insufflation accidents (parietal gangrene) [16], lithiasis lost after accidental opening of the gallbladder in peroperative surgery [1], The migration of metallic clips into the abdominal cavity [11], and the dissemination of cancer of the vesicle of fortuitous discovery [9]. Laparoscopic technique for cholecystectomy has continued to evolve, on the one hand, towards the reduction of the number of trocars and on the other hand, the reduction of their diameter in order to improve the aesthetic result [13,15, 18].

CONCLUSION

The laparoscopic pathway has rapidly established itself as the first reference route for cholecystectomy. Despite the technical progress of this surgery, some complications, although rare, can occur.

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