

Day case laparoscopic cholecystectomy

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Abstract

Since the introduction of laparoscopic cholecystectomy (LC) its indications have been growing at the same time as the surgeon's skill and improved instrumentation and anaesthesia. Nowadays in many hospitals the contraindications are those of general anaesthesia, the presence of intestinal obstruction or peritonitis, where there is a high risk of carbonic acidosis and the last months pregnancy. These are the ones that are used in our unit. We study, retrospectively, the LC done in our unit. We have studied the LC done on our unit from April 1994 to November 1997. The total number of cases was 286. Multiple surgery was performed in 3.49% cases. We found associated risk factors in 25.87%, complications in 3.49%, conversion to laparotomy in 2.45%, reoperation in 0.34%, readmission in 1.74%. We had no mortality. The mean stay was 1.61 days; 167 patients (58.39%) less than 24 h. The absence of mortality, low morbidity in high risk patients and short stay makes LC the best choice for cholecystectomy. A high percentage of LC cases may be dealt with on a day case basis. © 1998 Elsevier Science B.V. All rights reserved.

Keywords: Laparoscopic cholecystectomy; Day surgery

1. Introduction

It is accepted world wide that laparoscopic cholecystectomy (LC) is the ideal treatment for symptomatic cholelithiasis.

Cholecystectomy is one of the most common major surgical procedures in any surgical department. The use in these cases at the laparoscopic technique in a day surgery regimen offers benefits to both patients and health care institutions.

2. Patients and methods.

We have studied retrospectively the LC done in our unit from April 1994 to November 1997. The epidemiology, morbidity, length of stay and final results have

been analysed. The total number of cases was 286 (217 women and 69 men) with a mean age of 54–74 years, 206 cases were operated on in the afternoon. There were no emergency cases and all were operated on by laparoscopic surgery.

In order to reduce postoperative pain we work with a low gas pressure, perform a meticulous cleaning of the abdominal cavity and irrigate the liver dome with bupivacain. The gallbladder is taken out using an 'endobag'.

3. Results.

Multiple surgery was performed in ten cases (Table 1). We found associated risk factors in 74 patients (25.87%) (Table 2), complications in ten (3.49%) (Table 3), conversion to laparotomy in seven (2.45%), reoperation in one (0.34%), readmission in five (1.74%). There was no mortality (Table 4).

The mean stay was 1,61 days. 207 cases (72.37%) with stayed less than 36 h and 167 patients (58.39%) less than 24 h (Table 5).

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4. Discussion

Our results confirm that LC can be applied to all patients when there is no contraindication to general anaesthesia, no bowel obstruction, no peritonitis, no carbonic acidosis and the patient is not in the last months of pregnancy [1,2].

We have used LC in high-risk patients according to the criteria of many authors [3–6].

Table 1
Multiple surgery: ten cases (3.49%)

	Mean stay (days)	No. cases
Oophorectomy	1	1
Abdominal wall hernia	3	1
Groin hernia	1–6	5
Umbilical hernia	2	1
Anal fissure	1	1
ERGE. Hiatus hernia	3	1

Table 2
Risk factors: 74 cases (25.87%)

Sintron
Morbid obesity
Kidney horseshoe
Multiple laparotomy supramesocolic
Depressive syndrome
Kidney graft
Gallbladder infection
Cardiac insufficiency
HTA
HTA and DMID
DMID
Lung metastases (Hipernephroma)
EPOC
Anterior cholecystostomy
Coronary insufficiency
Cholecystocolic fistula
Supra renal insufficiency
Cardiac transplant

Table 3
Complications: ten cases (3.49%)

Complication	No. cases	Stay (in days)
Wound infection	1	3
Neural pain	1	5
Bowel obstruction	1	6
<Potassium	1	17
Port bleeding	1	3
Hematoma	1	8
Abdominal pain	1	3
Liver bleeding	1	17
Biliar, leakage	1	10
Biliar, leakage	1	18
Biliar, leakage	1	10

Table 4

	Cases	%
Total	286	100
Multiple surgery	10	3.49
Risk factors	74	25.87
Complications	10	3.49
Conversion	7	2.45
Reoperation	1	0.34
Readmission	5	1.74
Mortality	0	0

Table 5
Stay in hospital: mean stay of total cases 1,61 days

	No. cases	%
< 36 h	207	72.37
< 24 h	167	58.39

We have used all techniques described to obtain a better postoperative course and reduce hospital stay [7–10]. We have not applied any preoperative selection criteria in order to determine the hours of hospital stay of the patient [11–13].

The absence of mortality, low morbidity in high-risk patients and short stay makes the LC the best choice for cholecystectomy. A high percentage of cases can be undertaken on a bay basis.

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