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Diagnosis And Surgical Correction Of Postoperative Bile Leakage In Patients After Operations On The Liver And Biliary Tract

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Background : Improving the immediate results of surgical treatment of diseases of the liver and biliary tract.

Methods : We have experience in diagnosing and treating 142 patients with postoperative bile leakage who were treated at the Clinic for Surgical Diseases No. 1 from 2008 to 2022. There were 62 men (43.7%), 80 women (56.3%). The age of the patients ranged from 24 to 78 years. In 75 (52.8%) cases, bile leakage developed after planned (n=39) and urgent surgical (n=36) interventions on the liver for focal diseases (n=68) and traumatic liver injuries (n=7). In 65 (45.8%) cases, bile leakage occurred after operations on the biliary system for cholelithiasis and its complications performed by traditional (n=34) and videolaparoscopic methods (n=31) in planned (n=14) and emergency (n= 17) okay. In 2 more patients with residual choledocholithiasis, bile leakage developed after percutaneous transhepatic cholangiostomy. A special group consisted of 2 (1.4%) patients with postbulbar duodenal ulcer, operated on an emergency basis for a bleeding penetrating ulcer, in whom bile leakage was observed after gastric resection.

Results : Endoscopic and combined videolaparoscopic interventions for the treatment of postoperative bile leakage were effectively used in 54 cases. In 17 cases, endoscopic papillosphincterotomy (EPST) was used to prevent bile leakage and correct biliary hypertension. At the same time, in 6 cases, biendoscopic interventions were performed in the form of relaparoscopy with re-clipping of the cystic duct and EPST (n=4) and relaparoscopy with sanitation and drainage of the subhepatic space and endoscopic transduodenal prosthesis (n=2). In 17 cases, laparoscopic debridement and drainage of the subhepatic space with coagulation of the liver stump (n=5) were performed, and only in 4 cases they resorted to puncture and drainage of the biloma under ultrasound control. In 6 cases, with bile leakage, caused by damage to the hepaticocholedochus, they resorted to the formation of hepaticojejunoanastomosis on an isolated loop according to Roux. In 6 more cases, to prevent bile leakage, relaparotomy was performed with stitching of the cystobiliary fistula (n=4) and liver stump (n=2), sanitation and drainage of the abdominal cavity. Complications and lethal outcomes were not observed.

Conclusions : With mild severity of bile leakage, the absence of peritonitis and biliary hypertension, conservative therapy is advisable. With moderate and severe severity of bile leakage and the presence of biliary hypertension, it is necessary, according to indications, endoscopic or surgical methods of correction.

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