Postcholecystectomy Syndrome

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Özet: *Postkolesistektomi sendromu kolesistektomi sonrası, abdomenin sağ üst bölgesinde mevcut ağrıların devam etmesi veya tekrar oluşması şeklinde tarif edilir. Yaklaşık olarak, vakaların üçte birinde olay Bilier sistemin dışından kaynaklanır. Koledok taşı, ampuller darlık bilier sesteme ait en sık görülen nedenlerdir. Abdominal sonografi, endoskopik retrograd colanjiopankreatiko-grafi (ERCP) teşhis yöntemleridir. Transpapiller monometri, hepatiobilier sintigrafi (HBS) gelecek vaad eden tanı yöntemlerdir. Başarılı bir tedavi, doğru teşhis sayesinde gerçekleşebilir.*

Anahtar kelimeler : Postkolesistektomi sendromu

Summary : *Postcholecystectomy sendrome (PS) is described as the recurrence or persistence of pain or other symptoms in the right upper abdominal, quadrant following cholecystectomy. Nearly one-third of the cases will be due to disease outside the biliary tract. Choledocholithiasis, ampullary stenosis are often the causes releated to the biliary tract. Abdominal ultrasonography, endoscopic retrograde cholongiopancreaticography (ERCP) are the diagnostic tools. Transpapillary manometry and hepatobiliry scintigraphy (HBS) are newer tests of great promise. A successfull treatment depends on the correct diagnose.*

Key words : Postcholecystectomy syndrome

The "Postcholecystectomy sendrom" (PS) is a complex clinical problem with a variety of causes (1). The term was first used by Womack and Crider (2) to describe complaints of recurrent upper abdominal pain after cholecystectomy. Patients return in three months to many years later with symptoms identical to those for which the operation had been performed. The sendrom has been noted to occur in up to 5 per cent of the patients operated on for stone disease of the biliary tract that is oftan resistant to both medical and surgical treatment (2, 3). In a recent study of 65 cases, 26 patients were found to have diseases located out side the biliary tract (3), in another review of 5859 biliary tract operations, 34 per cent of the patients with PS had disorders out side the hepatobiliary system (2).

ETIOLOGY

The etiology of PS couldn't be defined fully and eventually is not caused by only one factor. The predisposing factors are either intrinsic (hepatobiliary) or extrinsic (non hepatobiliary). The intrinsic causes are common bile duct stone, a retained segment of gallbladder, an operative error performed on biliary tract, such as a stricture of the biliary tree, along cystic duct remnant, stenosing papillitis and biliary dyskinesia (2, 3, 4). The extrinsic etiologic factors include duodenal or gastric ulcer, reflux esophagitis, chronic pancreatitis, irritable bowel syndrome, duodenal diverticula, wound neuroma, malignancy and pschiatric problems. Psychic vulnevability may exert its influence on out come in two ways: preoperativly it may influence the decision to undertake the operation and postoperativly it may interefere with measures of out come. Biliary dyskinesia (BD) is used to describe the impaired motility of the common bile duct and abnormal flow of bile from the liver to the duodenum. The etiology of BD is not clear. It may be as a result of the spasm of the sfincter that increases intraductal pressure and thus produce pain. Papillary stenosis occurs as a result of acute or chronic inflamation of the papilla vater (5). But the

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presence of large amount of collagen in the papilla makes the pathological diagnosis of inflamatory stenosis difficult.

DIAGNOSE

After the laboratory evaluation of a complete blood count, eritroset sedimantation rate (ESR), liver function tests, serum amylase, lipase, urinalysis, and a test for occult blood in the stuhl, a complete evaluation of upper and lower gastro intestinal tract must be compleated. Barium upper gastrointestinal series should be done. Endoscopic evaluation of esophagus, stomach, duodenum should be compleated. Especialy ERCP is helpful in the differential diagnosis of PS in patients suffering from symptoms suggesting obstruction. Patients suffering from acute upper abdominal pain associated with jaundice, fever and chills usually have common bile dust stone. Others having chronic pain of moderate severity without other associatel symptoms suggest a functional biliary disorders.

Transpapillary manometry is the most promising technique used in the differentional diagnosis of the functional diseases of the papilla. Patients with elavated transpapillary pressure respond favorably to transduodenoscopic sphincterotomy, which was first described in 1974 and now routene procedure throughout the world (7).

Evaluation using hepatobiliary sintigraphy (HBS) with techetium -n- substituted iminodiacet acid offers a non invasive, relative inexpencive widely available method of differentiating stenosis of sphincter or other causes of biliary obstruction from nonhepatobiliary causes.

TREATMENT

The treatment of PS depends on the etiology and may be either concervative or operative. The surgical interventions are sphincterotomy, sphincteroplasty, septectomi which is excision of septum between common bile duct and duct of wirsung. Spincteroplasty is added to this procedure too.

Long acting nitroglycerin (B), and nifedipine a calcium channel blocker (9) have therapeutic effects in the treatment of the functional disorders of the sphincter of oddi. The administration is used to distinguish between patients with functional and organic disarders of the sphincter of oddi too.

ERCP is used as a thereupatic tool to remove the common bile duct stones, endoscopic baloon dilatation relieves the symptoms of the organic causes of the sphineter of oddi. Spasmolitics, pancreatic enzym preparations bile acid substitutes, analgesics, and antiulcer drugs (H2 - receptor blockers, antacids, H^+ - K^+ ATP ase inhibitors, sucraltate) are used to relive the extrabiliary symptoms of PS.

Acknowledgement: We are indebted to Drs. C. Seven and M. Şavkılıoğlu for their valuable comments on the present study.

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