Aim of study. Cholangiocarcinoma represents about 3% of gastrointestinal tumors, making it the second most common primary malignant liver tumor. The diagnosis of the disease in most cases is established late, in the non-reseccable / metastatic stage (about 80%). The current trend is the use of radically aggressive surgical treatment or the palliative approach to decompression of the biliary tract in non-resecting cases.
Materials and methods. The study presents the retrospective analysis of 214 patients hospitalized in the period 2000-2023 in the Republican Clinical Hospital evaluated in the Surgery Clinic No.2. According to the Bismuth-Corlette classification, 23 patients were of type I and II, 19 - of type IIIA, 15 - of type IIIB. 157 cases were patients with Klatskin tumor type IV. The diagnosis was confirmed by clinical examination, laboratory tests, ultrasound examination, computed tomography and magnetic resonance cholangiopancreatography (MRCP). ERCP being the diagnostic method, as well as curative.
Results. Radical surgical treatment was applied to 63 patients (29.5%). Resection of the common bile duct with the formation of bihepaticojejunoanastomososis was performed in 23 cases, left hepatectomy – in 15 cases and right hepatectomy – in 17 cases with preservation of the integrity of the digestive tract through the loop Y a la Roux. In 8 cases in type IV – the right or left extended hepatic resection was performed.
Conclusions. The diagnostic algorithm in patients with Klatskin tumor includes clinical examination, laboratory investigations, abdominal ultrasonography, ERCP, magnetic resonance cholangiopancreatography. Radical surgical treatment in patients with Klatskin tumor consists of resection of the common bile duct, right or left hemihepatectomy.
Keywords. Cholangiocarcinoma, hepatectomy, bihepaticojejunoanastonosis

MANAGEMENTUL LEZIUNILOR IATROGENE ALE CĂILOR BILIARE. POST-COLECISTECTOMIA LAPAROSCOPICĂ

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Scopul lucrării. Analiza rezultatelor managementul leziunilor iatrogene ale căilor biliare (LICB) post-colecistectomia laparoscopică.
Materiale şi metode. Studiu retrospectiv-prospectiv efectuat în Institutul de Medicină Urgentă, Chişinău, pe 1905 de colecistectomii laparoscopice (lot I) în 5ani, cu rata conversiei 2% (n=39) şi 8 cazuri de LICB transferate (lot II) pentru icter postcolecistectomic (4), colecţie subhepatică (3) şi peritonită biliară (1).
Rezultate. Lot I – rata LICB 0,37% (n=7): 4 – cu colecistită acută, 3 – colecistită sclero-atrofică, diagnosticaţi intraoperator – 5, la apariţia bilioragiei – 2. LICB au fost confirmate prin colangiografie intraoperatorie (5) şi CPGRE (2). LICB (Strasberg) au fost: tipA (1), tipC (1), tipD (3), tipE_1 (1) şi E_2 (1). LICB tipE s-au rezolvat prin hepatojejunostomie (HJS) a la Roux pe dren Volker (2), tip D şi tip C – plastia CBP pe dren Kehr (4), tipA – ligaturarea ductului şi papilosfincterotomie (1). O complicaţie specifică (strictură postischemică a HJS), rezolvată prin drenare transparietohepatică şi remontarea HJS peste 10 săptămâni. **Lot II** – 8 LICB: 6 confirmate prin CPGRE, 3 colangiografie TPH și 1 prin RMN – tip E_1 (2), tip E_2 (2), tip E_3(2) şi tip D (2), rezolvate prin HJS(5) şi plastia CBP pe dren Kehr(2); 1-a tip E3 – prin colangiografie intraoperatorie, rezolvată în urgență prin drenarea ducturilor hepatice separat şi HJS ulterioară. Complicații specifice (strictura HJS) – 2, rezolvate prin enterotomie şi stentare cu stent metalic autoexpandabil, într-un caz după revizia repetată a HJS, tentativa stentării transparietohepatice eșuând din cauza imposibilității plasării ghidului transanastomotic.
Concluzii. Managementul LICB este strict dependent de momentul diagnosticului, tipul leziunii și competențele chirurgicale. Rezolvarea chirurgicală definitivă a LICB diagnosticate postoperator trebuie efectuată doar în centre specializate, primar fiind rezolvate complicațiile septice.
Cuvinte cheie. Litiaza biliară, colecistectomia laparoscopică, leziunea iatrogenă de calea biliară, management diagnostico-curativ

MANAGEMENT OF IATROGENIC BILE DUCT INJURY AFTER LAPAROSCOPIC CHOLECYSTECTOMY

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Aim of study. To analyze the clinical outcomes of the management of iatrogenic bile duct injury (IBDI) after laparoscopic cholecystectomy.
Materials and methods. Retrospective-prospective study conducted in the Institute of Emergency Medicine, Chisinau, on 1905 laparoscopic cholecystectomies (group I) in 5 years, with 2% conversion rate (n=39) and 8 cases of transferred LICB (group II) for post-cholecystectomy jaundice (4), subhepatic collection (3), and biliary peritonitis (1).
Results. Group I – IBDI rate 0.37% (n=7): 4 – with acute cholecystitis, 3 – scleroatrophic cholecystitis, diagnosed intraoperatively 5, at the appearance of bile leakage – 2. IBDI were confirmed by intraoperative cholangiography (5) and ERCP (2). The type of IBDI according to Strasberg: type A (1), type C (1), type D (3), type E1 (1) and E2 (1). Type E were treated by hepatojejunostomy (HJS) a la Roux on Volker drain (2), type D and type C – bile duct repair with Kehr drain placement (4), typeA - duct ligation and papillophincterotomy (1). One specific complication was registered (postischemic stricture of HJS), resolved by transparietohepatic drainage and HJS re-creation over 10 weeks. **Group II** – 8 IBDI: 6 confirmed by ERCP, 3 by TPH cholangiography and 1 by MRI – type E1 (2), type E2 (2), type E3 (2), and type D (2), resolved by HJS (5) and CBP placement on Kehr drain (2); type E3 by intraoperative cholangiography, resolved in emergency by separate hepatic duct drainage and subsequent HJS. Specific complications (HJS stricture) registered in 2 cases were resolved by enterotomy and stenting with self-expanding metal stent, in one case after repeated revision of HJS, attempted transparietohepatic stenting failed due to impossibility of transanastomotic guide placement.
Conclusions. Management of IBDI is dependent on the time of diagnosis, type of lesion, and surgical skills. Definitive surgical repair of post-operatively diagnosed IBDI should only be performed in specialized centers, septic complications being resolved primarily.
Keywords. Biliary lithiasis, laparoscopic cholecystectomy, iatrogenic bile duct injury, diagnostic-therapeutic management