A13

ОСТРЫЙ ХОЛАНГИТ И БИЛИАРНЫЙ СЕПСИС: ОСОБЕННОСТИ ПАТОГЕНЕЗА, ДИАГНОСТИКА И ЛЕЧЕНИЕ

Даценко Б.М., Борисенко В.Б.

Харьковская медицинская академия последипломного образования, г. Харьков, Украина

Цель исследования. Изучение закономерностей развития билиарного сепсиа у больных с синдромом механической желтухи, осложненной острым холангитом. Материалы и методы. Проведен анализ комплексного исследования 1357 больных, поступивших с клиникой механической желтухи. Желтушный период составил от 2 до 36 суток (в среднем - 16,3 суток). Программа обследования включала клиническую диагностику с определением триады Шарко (пентады Рейнольдса); степень органной дисфункции определяли по шкале SOFA; стандартная лабораторная диагностика была дополнена определением маркеров синдрома системной воспалительной реакции – прокальцитонина и С-реактивного белка. Инструментальная диагностика включала УЗИ органов брюшной полости в В- режиме, допплеровскую сонографию сосудов печени, папиллоскопию, эндоскопическую ретроградную холангиопанкреатографию, чрескожную чреспеченочную холангиографию, компьютерную томографию.Результаты: По данным комплексного обследования механическая желтуха без холангита выявлена у 461 (34%) больных, у 896 (66%) больных желтуха ослонилась развитием холангита, который в 583 (43%) наблюдениях трансформировался в билиарный сепсис. Выраженность клинико-лабораторных проявлений гнойного процесса желчных путей (SIRS – больше 2 признаков) зарегистрирована у 579 (83%) больных.Прогрессирующая желчная гипертензия сопровождалась нарастанием ишемии печени с уменьшением кровотока по воротной вене, развитием феномена бактериальной транслокации, подавлением иммунного статуса и развитием синдрома полиорганной недостаточности. Программа лечения включала местное лечение с неотложной декомпрессией желчных протоков (эндоскопическая папиллосфинкторотомия, литоэкстракция, литотрипсия, назобилиарное дренирование, стентирование) и интенсивную системную терапию с использованием рациональной антибиотикотерапии, гемодинамической респираторной, нутритивной поддержки, иммунозаменительной и коррегирующей гемостаз терапии.Выводы: Острый холангит и билиарный сепсис - разные проявления инфекционно- воспалительного процесса, развивающиеся на фоне предсуществующей механической желтухи, первый из которых протекает местно (в желчных путях), а второй генерализован в виде синдрома системной воспалительной реакции организма на расположенный в гепатобилиарной системе гнойный очаг. Тактика лечения билиарного сепсиса существенно отличается от таковой при холангите.

ACUTE CHOLANGITIS AND BILIOUS SEPSIS: PATHOGENESIS PECULIARITIES, DIAGNOSTICS AND TREATMENT

Aim of research. Study of bilious sepsis development regularities in patients with syndrome of mechanical icterus, complicated by acute cholangitis. Materials and methods. Analysis of complex research of 1357 patients attended to the clinics with mechanical icterus was carried out. Icterical period comprised from 2 to 36 days (average - 16,3 days). Program of examination included clinical diagnostics with Sharko triade (Reinolds pentalogy) definition; degree of organic dysfunction was defined according to SOFA scale; standard laboratory diagnostics was supplemented with definition of system inflammatory reaction syndrome markers - procalcitonin and C- reactive protein. Instrumental diagnostics included USR of abdominal cavity in B-regime, Doppler sonography of lever vessels, papilloscopy, endoscopic retrograde cholangiopancreatography, percutaneous translever cholangiography, computer tomography.Results: According to data of complex examination mechanical icterus without cholangitis was delineated in 461 (34%) patients, in 896 (66%) patients icterus was complicated by cholangitis development, which in 583 (43%) cases transformed into bilious sepsis. Expressiveness of clinic-laboratory manifestation of purulent process in bilious ways (SIRS – more than 2 signs) was registered in 579 (83%) patients. Progressive bilious hypertension was accompanied by lever ischemia buildup with bold flow decrease alone the portal vane, development of bacterial tanslocation phenomenon, immune status suppression with polyorganic incompetence syndrome development. Program of treatment included local treatment with urgent decompression of bile ducts (endoscopic papillosphincterotomy, lithoextraction, lithotripsy, nasobiliar drainage, stentastion) and intensive system therapy with the use of additional antobioticotherapy, hemodynamic respiratory, nutritive support, immunesubstitute therapy and therapy correcting hemostasis. Summary: Acute cholangitis and bilious sepsis are different manifestations of infection-inflammatory process, developing on the background of previous mechanical icterus, the first of which takes place locally (in bile ways), another is generalized in the way of system inflammatory reaction syndrome of the organism on a purulent focus located in hepatobilious system. Bilious sepsis treatment tactics differs essentially from that under cholangitis.

A14

SINDROMUL MIRIZZI – DIAGNOSTIC SI TRATAMENT

Popa Gh., Gutu E., Iacub V.

Introducere: Sindromul Mirizzi (SM) este o complicatie rara a litiazei veziculare cronice cu o incidenta de 0,7-1,4% la pacientii colecistectomizati. Initial SM a fost descris ca o obstructie totala sau partiala a caii biliare principale cu un calcul inclavat in infundibulul vezicular sau ductul cistic printr-o compresie extrinseca, complicata cu icterul obstructiv. Conform clasificatiei Csendes se disting urmatoarele tipuri de SM: tip I, cand calea biliara principala este comprimata de un calcul inclavat in infundibulul vezicular sau ductul cistic fara formarea fistulei colecistobiliare; tip II-IV cu prezenta fistulei colecistobiliare cu diferit grad de eroziune a canalului hepatic comun. Materiale si metode: Pe perioada anilor 2006-2011 raportam 5 cazuri de SM: 1 pacient cu SM tip I, 2 pacienti – tip II si 2 pacienti – tip IV. Doar la doi pacienti diagnosticul de SM a fost suspectat preoperator prin colecistopancreatografie retrograda endoscopica, iar in 3 cazuri diagnosticul a fost instalat intraoperator. La toti pacientii icterul mecanic era insotit de colangita purulenta. Rezultate: Operatia a avut ca scop colecistectomie cu lichidarea fistulei bilio-biliare si rezolvarea icterului obstructiv. Operatia

s-a finisat cu aplicarea anastomozei hepaticojejunale pe ansa Roux cu stent biliar (1 bolnav), drenarea coledocului tip Kehr (3), drenarea coledocului tip Halsted (1). Toti pacientii in perioada postoperatorie precoce au fost examinati prin fistulocolangiografie pentru controlul permiabilitatii cailor biliare. Concluzii: SM este o complicatie rara a litiazei veziculare, responsabil de icter si colangita, diferentierea preoperatorie cu cancerul biliar fiind dificila. Rezolvarea chirurgicala a SM depinde de forma morfopatologica conform clasificarii Csendes.

MIRIZZI SYNDROME – DIAGNOSIS AND TREATMENT

Introduction: Mirizzi syndrome (MS) is a rare complication of longstanding gallbladder stone disease, with an incidence of 0.7-1.4% from all cholecystectomies. SM was originally described as a gallstones impacted in the neck of the gallbladder or cystic duct, which can obstruct the common bile duct (CBD) by extrinsic compression causing obstructive jaundice. According to Csendes classification the following types of MS are distinguished: type I, when the CBD is compressed by a gallstone impacted in cystic duct, without biliary fistula, type II-IV with the bilio-biliary fistula with different degree of destruction of the common hepatic duct wall. Materials and methods: We report 5 patients with MS, treated during the period of 2006-2011: 1 patient with type I MS, 2 patients with type II, and 2 patients with type IV. Only in two patients the MS was suspected prior surgery using endoscopic retrograde cholecystopancreatography, in another three cases the diagnosis was established intraoperatively. Mechanical jaundice in all patients was accompanied by purulent colangitis. Results: The aim of surgery included cholecystectomy, abolition of cholecysto-choledochal fistula, and elimination of obstructive jaundice. Procedure was completed by Roux-en-Y hepaticojejunostomy with biliary stent placement (1patient), suture closure over a T-tube (3), and Halsted tube (1). In the early postoperative period all patients underwent cholangiography in order to control the permeability of the biliary ducts. Conclusions: MS is a rare complication of the gallbladder calculous disease which is responsible for obstructive jaundice and cholangitis, the preoperative differentiation with biliary cancer is difficult. The surgical procedure for MS depends on its morphological form according to Csendes classification.

A15

DUPLICATIA SI FALSA DUPLICATIE A AXULUI BILIAR PRINCIPAL. IMPLICATII DIAGNOSTICE SI TERAPEUTICE

Bratucu E., Straja D., Cirimbei C., Marincas M., Marincas M., Stefan I., Fatoi Diana

Institutul Oncologic BucurestiClinica de Chirurgie Nr. 1

Autorii prezinta doua cazuri de duplicatie a caii biliare principale, prin convergenta foarte joasa a canalelor hepatice. Unul dintre cazuri a reprezentat o duplicatie reala, incontestabila. Cel de-al doilea caz a fost interpretat initial ca o duplicatie pe baza examenelor colangiografice intraoperatorii si a colangiografiei endoscopice, interpretari care s-au dovedit eronate. Datele lamuritoare au fost oferite de reconstructiile colangio-RMN 3-D, in postoperator - falsa duplicatie in cazul unui alt tip de anomalie. Se desprinde ideea informatiei insuficiente oferite de explorarile imagistice colangiografice, cat si a colangioRMN standard, singura informatie de certitudine fiind oferita de reconstructiile colangioRMN 3D. Apare astfel evidenta necesitatea solicitarii de catre chirurg a imagisticii reconstructive 3D ori de cate ori este evocata o anomalie in aria cailor biliare extrahepatice. In acest mod s-ar afla mai rapid situatia anatomica reala si s-ar evita o serie de erori diagnostice sau chiar gesturi terapeutice neadecvate.

THE DUPLICATION AND FALSE DUPLICATION OF MAIN BILE AXIS. DIAGNOSTIC AND THERAPEUTICAL IMPLICATIONS

The authors present two cases of common bile duct duplications by way of very low convergence of hepatic ducts. One of these cases represented a real, unquestionable duplication. The latter has been initially interpreted as a duplication on the basis of cholangiographic intraoperative examinations and of endoscopic cholangiography, interpretations that proved to be erroneous. Clarifying data have been provided by cholangio- MRI reconstructions, after the operation- the false duplication as a part of another type of anomaly. In this way, the idea of insufficient information provided by cholangiographic imagistic explorations , but also by standard cholangio-NMR emmerges, the only information of certitude being offered by 3D cholangio-MRI reconstructions. Therefore the necessity for surgeon requesting 3D reconstructive imagistics to be performed each time an anomaly in the field of extrahepatic bile ducts is evidenced here. In this way, the real anatomic situation would be discovered faster and a series of diagnostic errors and inadequate therapeutical gestures would be avoided.
