Diagnostic and Treatment Tactics in Mechanic Jaundice

B. Belchev, G. Chobanov, Sht. Donev, M. Balcheva*
Department of Surgery, *Department of Internal Medicine, Dobrich

Effective complex treatment of patients with stop in the common bile duct after our days comprehensions in higher degree are in dependence of earlier diagnosis, the reasons and the level of obstruction of biliary ducts. The range of surgical procedures depends of necessity of removing the handicaps of biliary ways and on the other hand, the patient's possibilities and coexistent diseases.

During the period 1985-1991, 49 patients with mechanic jaundice are accepted in Department of Surgery, Dobrich. The age ranged 47-84 years. Women are 57. The basic diagnostic methods are: biochemical investigations, ultrasonography and ERCP. The surgical procedures performed are mainly cholecystectomy, choledocho-duodenostomy, transhepatic drainage and double internal drainage. When the patients undergo common duct exploration with choledocho-lithotomy, the tube drainage was rested.

Jaundice lasted at all 3 to 30 days until removing the handicap. An abdominal pain is noticed at 97 of the patients.

Transaminase levels are between 90-113 for SGOT and 45-253 for SGPT. Bilirubin levels noticed progress with advance for the direct one. Alkaline phosphatase activity ranged from 170-807 UI in different patients. The x-ray investigations of stomach and duodenum showed in the greater part of patients gastroduodenitis. The ultrasound findings described steatosis, dilatated common bile duct and tumour process of pancreas head. In 4.5% of the patients ultrasound technic was not realised because of gas in the subphrenic space and obesity. Few patients have undergone ERCP study.

Like jaundice as a reason the severe cholecystitis was at 33 of the cases (22%). The progressive jaundice, leukocytosis and the pain are the main reasons of immediately performed cholecystectomy in 12 patients.

Papilla Vatery's cancer was found until surgery in 11 of the patients (7%) but for advanced infiltrative tissue process only palliative procedures were performed - cholecystectomy and choledocho-duodenostomy in 4, cholecystogastroanastomosis - in 6, and hepato-jejunoanastomosis with Brown's anastomosis - in one patient.
The common bile duct stones were found at 48 patients (32%). Eleven of them have undergone double internal drainage for stones and ampullary stenosis. Pancreatic head cancer was diagnosed in 57 patients (24.84%). Twenty four of them had advanced infiltration and cholecystogastro-cholecystoduodenanastomosis, transhepatic drainage. Mortality rate after surgery was 4.4%. The other patients were discharged at 10-12 days because jaundice regressing. The pain escaped soon after stones removing but patients with neo processes ought to use opiates.

Diagnostic assessment included biochemical investigations, ultrasonography and ERCP.

Handlers found thickening as useful sign until Saunders and Zehrouni noticed that ultrasound thickening of the gallbladder wall was suspective. In 7% of the patients the echographic data were not equal with intraoperative ones. The later diagnosis in malignant diseases was preliminary palliative. Because the jaundice of different genesis was indication for emergency surgery, such ones are realised in 3-4 days after accepting patients in hospital. After CHGA and THD surveillance is 3-5 months for patients with CHDA.

Slower restriction of microcirculation after internal drainage is obvious for bile toxic products entering into blood flow comparatively with the decompression of ducts after external drainage.

The most common reason of mechanical jaundice is cholelithiasis. Biochemical and ultrasound findings are more used in jaundice character determination.

The method of surgery is determined of patients’ status, advances of pathologic process and the anesthesiologic risk connected with them.

Patients with stones in the bile ducts wide more than 2 cm are restricted faster after CHDA and ampullotomy.