

## Correction of iatrogenic injuries of the extrahepatic bile ducts and external bile fistulas using a minimally invasive technique

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**Abstract:** The problem of surgical correction of iatrogenic bile duct injuries (IBD) and external biliary fistulas (EBF) is one of the most pressing issues of abdominal surgery [1,2]. The urgency of the situation in APZhP and NZhS is due to the duration of the pathology, the increase in chronic obstructive jaundice and subsequent biliary cirrhosis, portal hypertension, purulent cholangitis, and liver failure. These patients undergo multiple restorative and reconstructive surgeries.

**Keywords:** reconstructive surgeries, intraoperative injuries, performing cholecystectomy.

The frequency of intraoperative injuries of the extrahepatic bile ducts reaches 0.2 - 3% of the total number of operations on the abdominal organs, and reconstructive operations lead to recurrence of strictures of the bile ducts and external bile fistulas (EBF) within 10-12%, and mortality in case of this ranges from 8 to 40% [3,4].

An analysis of the literature shows that in 90% of the cases, PVA are observed during cholecystectomy. If when performing cholecystectomy by laparotomic access, UAS occur from 0.8 to 1%, then with laparoscopic techniques they increase from 0.3 to 3% of cases [3,4]. Of course, the introduction of laparoscopic technology is evidence of the progress of medical science and practice, however, an increase in the number of laparoscopic interventions at the stage of mastering this technique inevitably leads to all kinds of complications. These iatrogenic complications require repeated high-tech interventions, not to mention the fact that the fate of these patients is sometimes dramatic.

Resections of the stomach lead to UAD in 0.4-9.1%, which is primarily due to the level of professional training of the surgeon, as well as the severity of the inflammatory-destructive process on the elements of the hepatoduodenal ligament.

Numerous restorative and reconstructive operations performed for this pathology, unfortunately, cannot be considered satisfactory. The possibilities of a relatively new direction in biliary tract surgery, endobiliary stenting, remain controversial [5,6]. As a result, further improvement of sparing methods of surgical treatment of iatrogenic lesions of

hepaticocholedochus and SJ remains a demanded problem, and discussions on this problem should end with an optimal solution.

Objective: To improve the results of surgical treatment of iatrogenic injuries of the extrahepatic biliary tract and external biliary fistulas using sparing endoscopic technologies.

Material and methods. Endoscopic retrograde cholangiopancreatography (ERCP) and polypositional fistulography are of decisive importance in the diagnosis of intraoperative injuries, cicatricial strictures and SVC to clarify the nature of the pathology and the choice of tactics for its elimination. We performed ERCP using a duodenofibroscope with side optics JF-B(B2), JF-10 from Olympus (Japan). In “RS NPM TsKH named after yeni and cad. V. Vakhidov ” from 2010 to 2022 296 studies were carried out . Of this number, ERCP was combined with subsequent endoscopic papillosphincterotomy (EPST) in 173 patients. Control ERCP was performed after EPST in 94 patients. The bougienage of the stenotic segment was carried out with biopsy forceps with local diathermocoagulation of the difficult-to-bouginate scar segment. After that, stenting of the stenotic site was performed. Standard endobiliary stents were used.

Results and its discussion. According to our data, the cause of the formation of cicatricial strictures and fistulas were: damage to the bile ducts and their inadequate drainage during cholecystectomy (9.2%), resection of the stomach (7.0%) and echinococcectomy (2.8%).

We performed 173 endoscopic transduodenal stentings of stenotic areas of the extrahepatic biliary tract after primary surgical interventions. In all cases, hepaticocholedochal strictures were found, which formed an external biliary fistula. At 36 cases, the stricture was located in the confluence zone and was of a critical nature, accompanied by the progression of obstructive jaundice. In this group of patients, direct bilirubin ranged from 200 to 300  $\mu\text{mol/l}$ . Thirteen patients had initial signs of liver failure in the form of manifestations of encephalopathy, a decrease in albumin levels below 30 g/l, and a decrease in the prothrombin index below 82%. In 53 cases, the obstruction was located at the confluence of the cystic duct part of the common bile duct. The content of direct bilirubin in these patients ranged from 300 to 390  $\mu\text{mol/l}$ . They were delivered to our hospital before the development of liver failure. Using the endoscopic method, it was possible to restore the patency of the lumen of the hepaticocholedochus, and to carry out stenting of the stenotic segment, which led to recovery and discharge of patients after 6-8 days. In order to prevent encrustation of the drainage tube, a constant intake of deoxycholic acid preparations (henochol, chenofalk, ursosan) was prescribed. All these patients were under constant control in the postoperative period. There were no

complications associated with stenting of the external bile ducts in any case. At different times (from 6 to 10 months), the stents were removed by duodenoscopy.

Findings. Thus, the cause of intraoperative injuries, cicatricial strictures and external biliary fistulas is

There are tactical and gross technical errors during primary operations, more often during cholecystectomy.

Methods of endobiliary stenting are one of the main methods for correcting iatrogenic damage to the EBD and SGA. In a certain number of cases, they prevent patients from severe and sometimes repeated surgical interventions.

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2019-2023