Žučni kamenci i pravo vreme operacije – čekati ili intervenisati?

Sužetak

Uvod. Žučna kalkuloza (ŽK) je najčešći uzrok bilijarnog pankreatitisa. Nakon smirivanja akutne faze pankreatitisa (AP), u skoro svim slučajevima primenjuje se hirurško lečenje (holecistektomija).

Cilj rada. Prikazati pravo vreme za operaciju žučnih kamenaca u slučaju pankreatitisa kao komplikacije.

Prikaz slučaja. Pacijent starosti 85 godina, javlja se zbog bolova u trbuhu. Pacijent afebrilan, eupnoičan, bleđe boje kože, normalne prebojenosti vidljivih sluznica; TA 140/80 mmHg, difuzna bolna osetljivost abdomena. Nativni rendgen abdomena pokazao je hidroaerične nivoe. Pacijent upućen hirurgu i hitno je operisan. Nije urađena holecistektomija. Zbog kardiovaskularne bolesti i promena na krvnim sudovima, pacijent je imao dve kardiohirurške intervencije. Tri meseca nakon kardiohirurškog zahvata, pacijent se javlja izabranom lekaru jer je požuteo. Fizikalnim pregledom ustanovljeni jača prebojenost kože i vidljivih sluznica, afebrilan, bez bolne osetljivosti abdomena. Pregledom krvi na infektivne agense, negativna antitela na viruse hepatitisa B, C i HIV . Abdominalnom ultrasonografijom viđen kamen u žučnoj kesici, postoji opasnost od recidivantnog bilijarnog pankreatitisa. Pacijent podvrgnut operativnom zahvatu totalne holecistektomije.

Zaključak. Pacijenti sa žučnim kamencem imaju povećan rizik od akutnog pankreatitisa. Holecistektomiju treba obaviti za vreme prve hospitalizacije kod postojanja kalkuloze žučne kesice sa komplikacijom bilijarnog pankreatitisa.

Ključne reči: žučni kamenci, pankreatitis, holecistektomija, primarna zdravstvena zaštita

Gallstones and timely surgical intervention – wait or operate?

Abstract

Introduction: Gallstones are the most common cause of biliary pancreatitis. After the alleviation of the acute phase of pancreatitis, the surgery follows in the majority of cases (cholecystectomy).

Objective: To present when is the right time for surgical intervention in gallstone cases after pancreatitis as a complication.

Case report: An 85-year-old patient presents with abdominal pain. He is afebrile, eupnoeic, pale, BP 140/80 mmHg, with diffuse abdominal tenderness to palpitation. Native abdomen X-ray shows hydroaeric levels. The patient was referred to a surgeon and operated on urgently. Cholecystectomy was not performed. Due to cardiovascular disease and problems with blood vessels, the patent had had two cardiosurgical interventions in the past. Three months after cardiosurgical intervention the patient presents with jaundice at his CiP office. Physical examination confirms the yellow color of skin and mucosae. The patient is afebrile, without abdominal tenderness. Serological blood tests were negative for hepatitis B, C, and HIV. Abdominal ultrasonography showed a stone in the gallbladder and it was consistent with greater risk of recidivant biliary pancreatitis. The patient was operated and the total cholecystectomy was performed.

Conclusion: Patients with gallstones are at higher risk for acute pancreatitis. In patients with gallstones and consecutive biliary pancreatitis as a complication, cholecystectomy should be performed during the first hospitalization.

Keywords: gallstones, pancreatitis, cholecystectomy, primary health care
Introduction

Acute biliary pancreatitis is on the rise worldwide. One of the possible reasons is the rise in the number of obese people, which bears higher risk of gallstones. The gallstones originate from the precipitation of the gallbladder contents, cholesterol, and bilirubin. Due to the lack of symptoms, many patients are unaware of their existence. Over 70% of gallstones are asymptomatic. Clinical manifestations of gallbladder calculi vary, and the disease may start abruptly with abdominal pain, nausea, vomiting, intermittent fever. Jaundice is rare.

Abdominal sonography is a diagnostic method of choice for gallbladder calculi, and its complications. Complications such as septicemia, peritonitis, ileus are rare. Gallstones are the most common cause of biliary pancreatitis. Bile activates pancreatic enzymes, thus causing a cascading reaction of enzymatic damage and autodigestion of the pancreas. The treatment of acute gallbladder inflammation includes the use of medications and surgery. The acute phase treatment includes pain alleviation, infection healing, and improvement of the patient’s general condition. After the alleviation of the acute phase of the disease, surgical intervention is performed in the majority of cases (cholecystectomy).

The incidence of acute pancreatitis varies worldwide, due to different etiological factors. It ranges from 5% to 80% in the EU countries, with a somewhat lower incidence in the United Kingdom (England, Scotland), Netherlands, Germany, and a high incidence in Finland. The most common cause of acute pancreatitis (40% - 70%) is biliary tract disorders, followed by alcohol abuse (25% - 30%). The Serbian research data show gallstones are the most common cause of acute pancreatitis (around 51%).

Objective

Our article aimed to show the right time for surgical intervention in gallstone cases with consecutive pancreatitis as a complication.

Case report

We presented the case of an older male patient with two episodes of acute pancreatitis before the cholecystectomy was performed. The methodology included a case report from the GP practice in the Primary health center, Novi Beograd and a review of the patient’s medical records.

An 85-year-old patient, retired, presents at his GP’s office with abdominal pain. He denies any other health problems. His medical history includes hypertension, diabetes, benign prostate hyperplasia. He doesn’t smoke or drink alcohol. He has no known allergy to medications. He doesn’t smoke or drink alcohol. He has no known allergy to medications.
Dijagnoza po otpustu: Pancreatitis acuta. Ileus paralyticus, Diverticulosis sygmoidei colonis, operacija: Laparotomia explorativa, Adhaesiolisys. Otpušta se iz bolnice operisano i sa savetom da se pridržava higijensko-dijetetskog režima. Nije učinjena holecestektomija. 

U narednih godina dana pacijent je dva puta hospitaliziran na kardiouhirurgiji zbog kardiovaskularnog oboljenja i promena na krvnim sudovima (Substitutio valvulae aortae cum biocor valve. No 23; By-pass aortocoronarius simplex; Stenosis arteriae carotis internae dex. 85% et sin. 30%).

Tri meseca nakon drugog kardiouhirurškog zahvata pacijent se javlja izabranom lekaru jer je požuteo. Fizikalnim pregledom ustanovljena žuta prebojenost kože i vidljivih sluznica, afebrilnost, bez bolne osetljivosti abdomena. Biohemijski parametri pacijenta: sedimentacija 80 (SE, normalne vrednosti <20), total bilirubin 84.9 (normalne vrednosti <5.1), alkalna fosfataza 282, CRP 82, serum amilaza 340. Pregledom krvi na infektivne agense, negativna antitela na virushepatitisa B (HBS), C (HCV) i HIV. Abdominalnom ultrasonografijom videnia distendirana žučna kesa, granične deblije zida bez raslojavanja, intrahepatični žučni putevi segmentno dilatirani, duktuš holedohus proširen sa kalkulosom promera 8 mm. Dijagnostikovan holecestinski sindrom, postoji opasnost od recidivantnog bilijarnog pankreatitisa. Pacijent ponovo podvrgnut operativnom zahvatu, totalne holecestektomije. Dijagnoza po otpustu: Calculosa ves.fell; Pancratitis rec; Cholecystectomy.

Discussion

Gallstones are the frequent cause of acute pancreatitis. We presented the case of acute pancreatitis in an older man caused by the calculus of the gallbladder. Pancreatitis is more common in patients with gallstones. Murat et al showed that older patients, over 70 years of age and severe comorbidities have twice the higher risk of death.
Komorbidnost je prepoznata kao važan faktor kod pacijenata sa AP. Istraživanje u Srbiji pokazalo je da pacijenti sa značajnim komorbiditetima imaju povećan rizik od smrti u poredenju sa pacijentima koji ih nemaju, od 19 umrlih pacijenata, 16 (84,2%) je bilo sa komorbiditetima. Akutni pankreatitis je potencijalno fatalno bolest sa stopom smrtnosti oko 1% - 5%, ali poslednjih godina pokazuje tendenciju smanjenja. Da li je hirurg pri prvom operativnom zahvatu trebalo da odstrani žučnu kesicu u kojoj je bilo prisutno kamenje, da bi se time izbegla ponovna hirurška intervencija i recidivirajući pankreatitis. Istraživanja ukazuju da je bolje sprovesti operaciju odstranjenja ŽK što ranije, jer je pojava komplikacija manja. Odlaganje holecistektomije za nekoliko nedelja izlaže pacijenta riziku od razvoja komplikacija ŽK. Mala incidencija komplikacija u vezi sa holecistektomijom, sugerira da se ona sigurno može obaviti tokom hospitalizacije. Johnstone i saradnici preporučuju holecistektomiju kao definitivni tretman tokom prve hospitalizacije ili u roku od dve nedelje od prijema, radi smanjenja rekurentnog pankreatitisa. U njihovom istraživanju 11% pacijenata je ponovo hospitalizirana sa dijagnozom recidivirajućeg pankreatitisa. Istraživanje ukazuju da ŽK iniciraju napad pankreatitisa, ali ne i progresiju bolesti koja zavisi od količine enzima za varenje. Sigurno je da holecistektomija treba da se obavi za vreme prve hospitalizacije. Nisu pronađene razlike u zastupljenosti komplikacija među pacijentima koji su podvrgnuti ranoj holecistektomiji nasuprot kasnoj holecistektomiji. U svrhu lečenja, pored adekvatnog higijensko-dijetetskog režima medikamentne terapije, sprovodi se i hirurško lečenje. Ciljano lečenje pacijenata sa ŽK smanjuje morbiditeta, mortalitet i troškove lečenja. Ograničenja ovog prikaza slučaja su što su prikazani podaci u vezi dijagnostičkih procedura i terapije urađeni na sekundarnom nivou, prikazani na osnovu dobijene opšute liste pacijenata. U svakom slučaju nadamo se da predstavljeni podaci mogu poslužiti u podsticanju poštovanja i unapređenja postojećih smernica za sprečavanje ponavljajućeg pankreatitisa usled žučnog kamenca.

Zaklučak

Pacijenti sa žučnom kalkulozom imaju povećan rizik od akutnog pankreatitisa. Pankreatitis treba tretirati u skladu sa uzrokonom, ciljano i multidisciplinarno. Holecistektomiju treba obaviti za vreme prve hospitalizacije kod postojanja kalkuloze žučne kesice sa komplikacijom bilijarnog pankreatitisa. Smanjuje se rizik od ponavljajućih epizoda pankreatitisa, koji predstavlja značajan problem sa pridruženim komorbiditetima i potencijalnom smrtnošću.

Comorbidity is recognized as an important risk factor in patients with acute pancreatitis. The Serbian research showed the patients with severe comorbidities were at higher risk of death, compared to those without them. Of 19 patients who died, 16 (84.2%) were with comorbidities. Acute pancreatitis is a potentially fatal disease, with the death rate 1% - 5%, with decreasing tendency in recent years. Should the surgeon have removed the gallbladder which contained gallstones during the first surgical intervention and thus avoided repeated surgical intervention and recurrent pancreatitis? The research shows it is better to perform cholecystectomy as soon as possible because there are fewer complications. Postponing cholecystectomy for a few weeks puts a patient at risk of complications. A small incidence of complications connected with cholecystectomy suggests that it may be performed during the same hospitalization. Johnstone et al recommend cholecystectomy as a definitive treatment during the first hospitalization or within two weeks from hospital admission, in order to reduce the incidence of recurrent pancreatitis. Their research showed 11% of patients were readmitted with the diagnosis of recurrent pancreatitis. The research data indicate gallstones initiate pancreatitis attacks, but not the progression of the disease which is dependant on the number of digestive enzymes. It is safe to say, cholecystectomy should be performed during the first hospitalization. No difference was found in the representation of complications among patients who underwent early cholecystectomy as opposed to late cholecystectomy. For the sake of treatment, besides adequate nutritional habits, medications, surgical treatment is also performed (cholecystectomy). Targeted treatment of patients with gallstones decreases morbidity, mortality and treatment costs.

The limitations of this case report are due to the data we were unable to obtain during the hospital treatment (diagnostic procedures and medications), which were reported in the discharge papers. Anyhow, we do hope that the presented data may serve as an incentive in following and upgrading current guidelines for the prevention of recurrent pancreatitis due to gallstones.

Conclusion

Patients with gallstones are at higher risk for acute pancreatitis. Pancreatitis should be treated in accordance with the cause, targeted and multidisciplinary. Cholecystectomy should be performed during the first hospitalization in the cases of gallbladder calculus with biliary pancreatitis as a complication. It reduces the risk of recurrent pancreatitis. Pancreatitis is a severe problem, especially if combined with comorbidities, in which case it raises mortality risk.
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