



ORIGINAL REPORT

Percutaneous cholecystostomy to treat acute cholecystitis in patients with high risk for surgery[☆]



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KEYWORDS

Acute cholecystitis;
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Abstract

Objective: To evaluate the results of percutaneous cholecystostomy for urgent treatment of acute cholecystitis, with the aim of identifying factors that predict survival. To analyze the recurrence of cholecystitis after catheter withdrawal in patients considered unsuitable candidates for delayed surgery, with the aim of identifying factors that predict recurrence.

Material and methods: We reviewed 40 patients who underwent percutaneous cholecystostomy in a two-year period. We analyzed survival during hospitalization in relation with fever, abdominal pain, leukocytosis, and C-reactive protein before and after the procedure. We analyzed the recurrence of cholecystitis after catheter withdrawal in patients considered unsuitable candidates for delayed surgery, as well as the influence of obstruction seen on cholangiography, age, sex, and comorbidities on the recurrence rate.

Results: During the hospital stay, 4 (10%) patients died of septic shock. Cholecystostomy improved fever, leukocytosis, and abdominal pain within five days of the procedure, but these improvements did not have a statistically significant effect on survival and were not therefore considered useful prognostic factors. Among the 15 patients considered unsuitable candidates for delayed surgery, 6 (40%) had recurrences of cholecystitis during a mean follow-up period of 6.7 months after catheter withdrawal. We found no association between recurrence and any of the parameters analyzed.

Conclusions: Outcomes in our series of patients with high risk for surgery who underwent cholecystostomy for urgent treatment of acute cholecystitis were similar to those reported in other series. Withdrawing the catheter in patients considered unsuitable candidates for delayed surgery is not recommended due to the high risk of recurrence of cholecystitis in comparison with other series.

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PALABRAS CLAVE

Colecistitis aguda;
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Colecistostomía percutánea como tratamiento de la colecistitis aguda en pacientes con alto riesgo quirúrgico

Resumen

Objetivo: Evaluar los resultados de las colecistostomías percutáneas realizadas como tratamiento urgente de colecistitis aguda, en busca de predictores de supervivencia. Valorar la recurrencia de colecistitis tras la retirada del catéter en pacientes descartados para cirugía diferida, y buscar factores predictores de recurrencia.

Material y métodos: Se revisan retrospectivamente 40 pacientes sometidos a colecistostomía durante dos años. Se analiza la relación de la supervivencia durante el periodo de hospitalización con la evolución de fiebre, dolor abdominal, leucocitosis y proteína c reactiva después del procedimiento. Se analiza la recurrencia de colecistitis tras la retirada del catéter en pacientes descartados para colecistectomía diferida por alto riesgo quirúrgico, así como la influencia de la colangiografía no permeable, la edad, el sexo y las comorbilidades en el porcentaje de recurrencias.

Resultados: Durante la hospitalización fallecieron cuatro pacientes por *shock séptico* (10%). La colecistostomía mejoró significativamente la fiebre, la leucocitosis y el dolor abdominal en un máximo de 5 días tras el procedimiento, pero estas mejoras no tuvieron un efecto estadísticamente relevante sobre la supervivencia, por lo que no se consideran útiles como factores pronósticos. Entre los 15 pacientes descartados para cirugía hubo seis recurrencias de colecistitis (40%) con un seguimiento medio de 6,7 meses tras la retirada del catéter. Un paciente falleció por recurrencia. No se encontró asociación de recurrencia con los parámetros analizados.

Conclusiones: La colecistostomía ofrece resultados similares a los obtenidos en otras series como tratamiento urgente de la colecistitis aguda en pacientes con alto riesgo quirúrgico. La retirada del catéter en pacientes descartados para cirugía con colecistitis litiasica es una opción desaconsejable debido al elevado riesgo de recurrencia de colecistitis en comparación con otras series.

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Introduction

Acute cholecystitis (CA) is a common cause of acute abdominal pain in elderly people, its origin is usually lithiasic, and its most accepted treatment today is laparoscopic cholecystotomy (LC).¹⁻⁴ This procedure and even more open cholecystotomy presents great variations in its morbimortality depending on whether it is performed on patients with a high or low surgical risk, either in an urgent or deferred manner.¹⁻⁶ There is no unanimous definition of high-surgical-risk patient. The most frequently used assessment modality is the one proposed by the American Society of Anesthesiologists (the ASA Physical Status Classification System) that grades from ASA 1 (healthy patient) to ASA 6 (cerebral death), being ASA > 2 (for example, ASA 3, serious systemic disease) indicative of greater risk.^{1,5-7} On the other hand the trend to solve the acute episode with analgesia, hydration and antibiotic therapy, performing the surgery in a deferred manner, is being questioned due to the continued improvement of the results obtained by LC in the first 72 h of evolution in non-high risk patients.^{3,4,8} There are few prospective trials about the most adequate treatment for AC in high-surgical-risk patients or those with a poor response to conservative treatment, especially when it comes to the role of percutaneous cholecystotomy (PC).^{9,10} The CHOCOLATE¹¹ trial, a randomized, controlled study comparing the results of PC and LC in

high-surgical-risk patients is still in the pipeline. There are systematic reviews^{5,12} claiming that it is not possible to make a clear recommendation on the most adequate treatment in the trials available. There are guidelines based on expert consensus (Tokyo Guidelines) on diagnostic criteria, assessment of seriousness and therapeutic recommendations in AC.^{13,14} PC is recommended as first line therapy in Grade III or serious AC (AC associated with organic dysfunction), in patients with ASA 3-4 or situations such as pregnancy or acute non-lithiasic cholecystitis (ANLC).¹⁴⁻¹⁶ In patients non-responsive to medical therapy after the first 72 h, it is also the option recommended.^{9,14-16} PC attains vesicular drainage with a <1% mortality and a >80% positive response in almost all the series which allows us to delay the cholecystotomy, which when performed urgently in high-risk patients shows a mortality of up to 30%.^{1,2,5,10,15-18} In patients with ANLC or in a permanent high-risk situation, PC can be the only definitive therapeutic option, with a variable percentage of relapses after the removal of the catheter based on the series,^{7,19-24} which generates disparate recommendations between withdrawing^{21,24} or keeping the catheter indefinitely and changing it every 3 months, which seems to be the most widely accepted option.^{15,22}

The primary goal of this study is to evaluate the results obtained in our cholecystostomies in search for survival predictors during hospitalization. As a secondary goal we intend to find out the percentage of cholecystitis relapse after

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