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SURGICAL TECHNIQUE

Single-stage management of cholelithiasis and choledocholithiasis: Laparoscopic cholecystectomy and intra-operative endoscopic sphincterotomy (with video)

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Introduction

Choledocholithiasis is present in between 10 to 18% of patients undergoing cholecystectomy. The literature seems to favor single-stage management of cholelithiasis and choledocholithiasis as similar rates of morbidity, mortality and bile duct clearance have been reported [1]. Single-stage management should decrease the duration of hospital stay and the number of general anesthesia sessions necessary to completely clear gallstones from the bile duct [1].

Within this context, there are two therapeutic possibilities that can be performed during laparoscopic cholecystectomy: intra-operative endoscopic retrograde cholangiopancreatography (ERCP) with endoscopic sphincterotomy (ES) or surgical common bile duct exploration via the transcystic or choledochotomy routes [2].

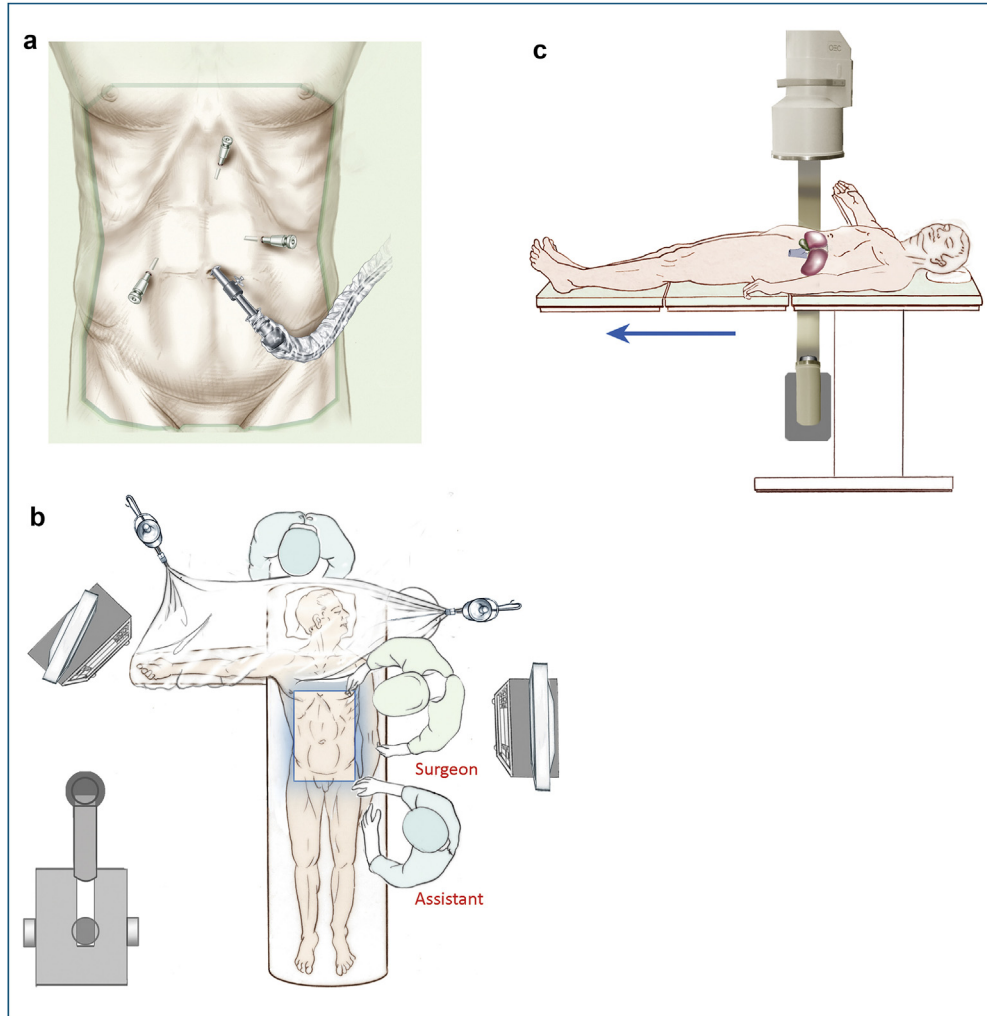
The management sequence of intra-operative ERCP+ES and laparoscopic cholecystectomy requires a close collaboration between endoscopist and surgeon as well as a specific installation of the endoscopic and radiological equipment in the operating room. When choledocholithiasis has been identified pre-operatively, cholecystectomy should be scheduled in conjunction with the endoscopist. In our experience, this limits the number of pre-operative procedures requiring general anesthesia (echo-endoscopy) or difficult-to-obtain imaging (MRI) and reduces the invasiveness of the procedure by obtaining a trans-cystic cholangiogram, obviating the need for

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32 a direct approach to the main bile duct, while facil-
33 itating the endoscopist's bile duct cannulation by the
34 "Rendez-vous" technique. This limits the complications of
35 endoscopy [3], and also reduces the number of biliary and

abdominal drains and the duration of hospital stay. This
strategy can be integrated into an enhanced recovery pro-
gram, and is feasible in 70% of patients including those
treated urgently [1].

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36 1 Patient position and location of trocars

37 The patient is positioned supine, with the left arm alongside. The operating table should be radiolucent to allow
38 intra-operative radiological studies and the table top is rolled as far as possible toward the surgical team (Fig. 1.B blue
39 arrow) allowing placement of the C-arm unit correctly under the patient. The surgeon stands to the patient's left [1] with
40 the assistant to right of the surgeon [2].

41 The laparoscopy tower is placed at the level of the patient's right shoulder.

42 Cholecystectomy is performed laparoscopically using three or four trocars. The camera is inserted through a 12 mm umbilical
43 trocar [3], and two operating trocars, one right pararectal (10 mm) [4] and the other in the left hypochondrium (5 mm) [5]
44 are inserted for manipulation. A 5 mm trocar can be added in the epigastrium for exposure [6].

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