ISW26-351-01 (0432)

EMPHYSEMATOUS CHOLECYSTITIS: A DO-IT-YOURSELF CHOLECYSTECTOMY AND THE IMPORTANCE OF EARLY SURGICAL TREATMENT

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Introduction:
Emphysematous cholecystitis (EC) occurs in 1-4% of acute cholecystitis, resulting from the invasion of the gallbladder by gas-producing bacteria. If left untreated EC can progress to gangrenous cholecystitis and lead to a mortality rate of up to 20%. This case report illustrates the importance of early surgical treatment.

Material and Method:
Case report and literature revision of EC.

Results:
86-year-old female with 1 week of right upper abdominal pain. Diagnosed through US with acute cholecystitis and started on ciprofloxacin by general practitioner. In the emergency department, she had normal WBC and RCP of 371 mg/L. Her CT scan showed EC with perihepatic liquid with an air bubble. With no US window for percutaneous drainage, she was started on Piperacilin-Tazobactam for conservative treatment. Due to fever, she repeated the CT scan on day 3, showing a perihepatic abscess. She was submitted to laparoscopic cholecystostomy and abscess drainage on day 4. On day 6 the patient worsened and the abscess drainage became biliary. She was submitted to cholecystectomy on day 7. Intraoperatively, we found a biliary peritonitis with a gangrenous gallbladder unattached to the vesicular fossa and cystic duct. Due to inability to safely visualize the cystic duct, a drain was placed and she underwent later ERCP with stent placement in the common bile duct. She improved and was discharged on the 19th day.

Conclusion:
EC is rare condition and as this case report highlights an early cholecystectomy can prevent its evolution to gangrenous cholecystitis or gallbladder perforation.

ISW26-351-02 (0382)

PRE-OPERATIVE ENDOSCOPIC PANCREATIC STENT INSERTION CANNOT REDUCE POST-OPERATIVE PANCREATIC LEAK AFTER DISTAL PANCREATECTOMY: RESULT OF A RANDOMISED CONTROLLED TRIAL

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Introduction:
Post-operative pancreatic fistula (POPF) remains a major problem after distal pancreatectomy (DP). This study evaluates whether pre-operative pancreatic stent placement can lower POPF rate by directing pancreatic juice away from pancreatic stump.

Material and Method:
Patients scheduled for DP+/-splenectomy were randomised for pre-operative pancreatic stent (PS) insertion by retrograde cholangiopancreatography (ERCP) or no pancreatic stent (NPS). Primary outcomes measured were incidence and grades of POPF. Secondary outcomes were mortality, morbidity, total length of hospital stay for operation and ERCP.

Results:
Between March 2022 and April 2025, 22 PS and 26 NPS were recruited. The patients were comparable on patient demographics, pre-operative blood tests, pathological diagnosis, operative approach and splenectomy rate. Within the PS group, one patient (4.5%) failed to have pancreatic stent insertion, while another patient developed mild acute pancreatitis after ERCP. The two groups were comparable in operative time, operative blood loss and total length of hospital stay. There was one 90-day mortality in the PS group. That patient developed massive intra-abdominal bleeding from splenic artery branch due to slipped metal clip on postoperative day 2 necessitating reoperations. Patient eventually died of liver failure on postoperative day 34. There was no difference in POPF rate: biochemical leak (PS 86.4% vs NPS 92.3%, p=0.649), grade B POPF (PS 13.6% vs NPS 0%, p=0.089), but PS had significantly more post-operative complications (50% vs 15.4%, p=0.010) (Table 1).

Conclusion:
Pre-operative pancreatic stent insertion cannot reduce pancreatic leak after distal pancreatectomy, but at the same time it is also associated with more post-operative complications.

Table 1 Patient demographics, histological diagnosis, operative approach and post-operative outcomes between pancreatic stent (PS) and no pancreatic stent (NPS) groups

	PS (n = 22)	NPS (n = 26)	*P*-value
Age	64.5 (43 – 83)	64 (57 – 86)	0.784
Sex (M: F)	11 (50.0%); 11 (50.0%)	14 (53.8%); 12 (46.2%)	0.790
BMI	24.6 (17.2 – 28.1)	22.1 (18.7 – 39.0)	0.147
ASA			
1	0 (0.0%)	0 (0.0%)	>0.999
2	12 (54.5%)	21 (80.8%)	0.051
3	10 (45.5%)	5 (19.2%)	0.051
Pathological diagnosis			
Cystadenoma/Cyst	7 (31.8%)	9 (34.6%)	0.838
Carcinoma of pancreas	2 (9.1%)	3 (11.5%)	>0.999
Neuroendocrine tumor	5 (22.7%)	8 (30.8%)	0.532
IPMN	5 (22.7%)	5 (19.2%)	>0.999
Accessary/Ectopic spleen	2 (9.1%)	0 (0.0%)	0.205
Chronic pancreatitis	1 (4.5%)	0 (0.0%)	0.458
Solid pseudopapillary tumor	0 (0.0 %)	1 (3.8%)	>0.999
Approach			
Open	5 (22.7%)	10 (38.5%)	0.241
Robotic/Laparoscopic	16 (72.7%)	15 (57.7%)	0.278
Robotic converted to open	1 (4.5%)	1 (3.8%)	>0.999
Splenectomy	15 (68.2%)	23 (88.5%)	0.152
Operative time (min)	205 (174 – 582)	235.5 (107 – 383)	0.077
Operative blood loss (ml)	100 (10 – 500)	100 (10 – 2100)	0.369
Complication	11 (50.0%)	4 (15.4%)	0.010*
Grade of complication			
II	3 (13.6%)	0 (0.0%)	0.089
III	7 (31.8%)	4 (15.4%)	0.177
V	1 (4.5%)	0 (0.0%)	0.458
Pancreatic fistula	22 (100.0%)	24 (92.3%)	0.493
Biochemical leak	19 (86.4%)	24 (92.3%)	0.649
Grade B	3 (13.6%)	0 (0.0%)	0.089
Grade C	0 (0.0%)	0 (0.0%)	>0.999
90-day mortality	1 (4.5%)	0 (0.0%)	>0.999
Length of stay (ERCP + OT) (days)	11 (8 – 41)	10 (8 – 30)	0.762

BMI: Body mass index

ASA: American Society of Anaesthesiologists

IPMN: Intraductal papillary mucinous neoplasm

ERCP: Endoscopic retrograde cholangiopancreatography

OT: Operation

* Statistically significant

ISW26-351-03 (0545)

PORTAL HYPERTENSION AND SECONDARY BILIARY CIRRHOSIS IN POST CHOLECYSTECTOMY BENIGN BILIARY STRICTURES: CAUSE, MANAGEMENT & LONG-TERM OUTCOMES.

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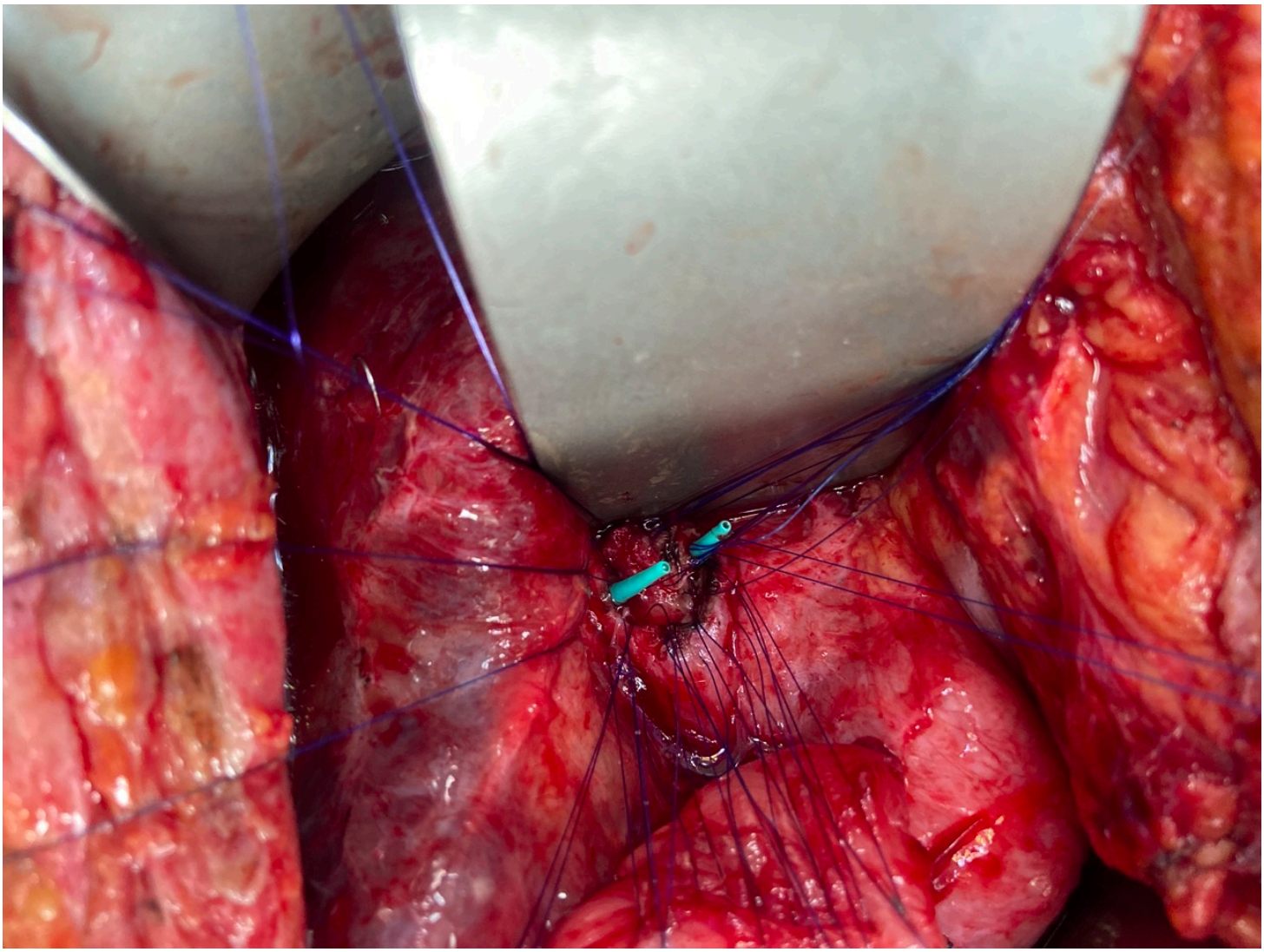
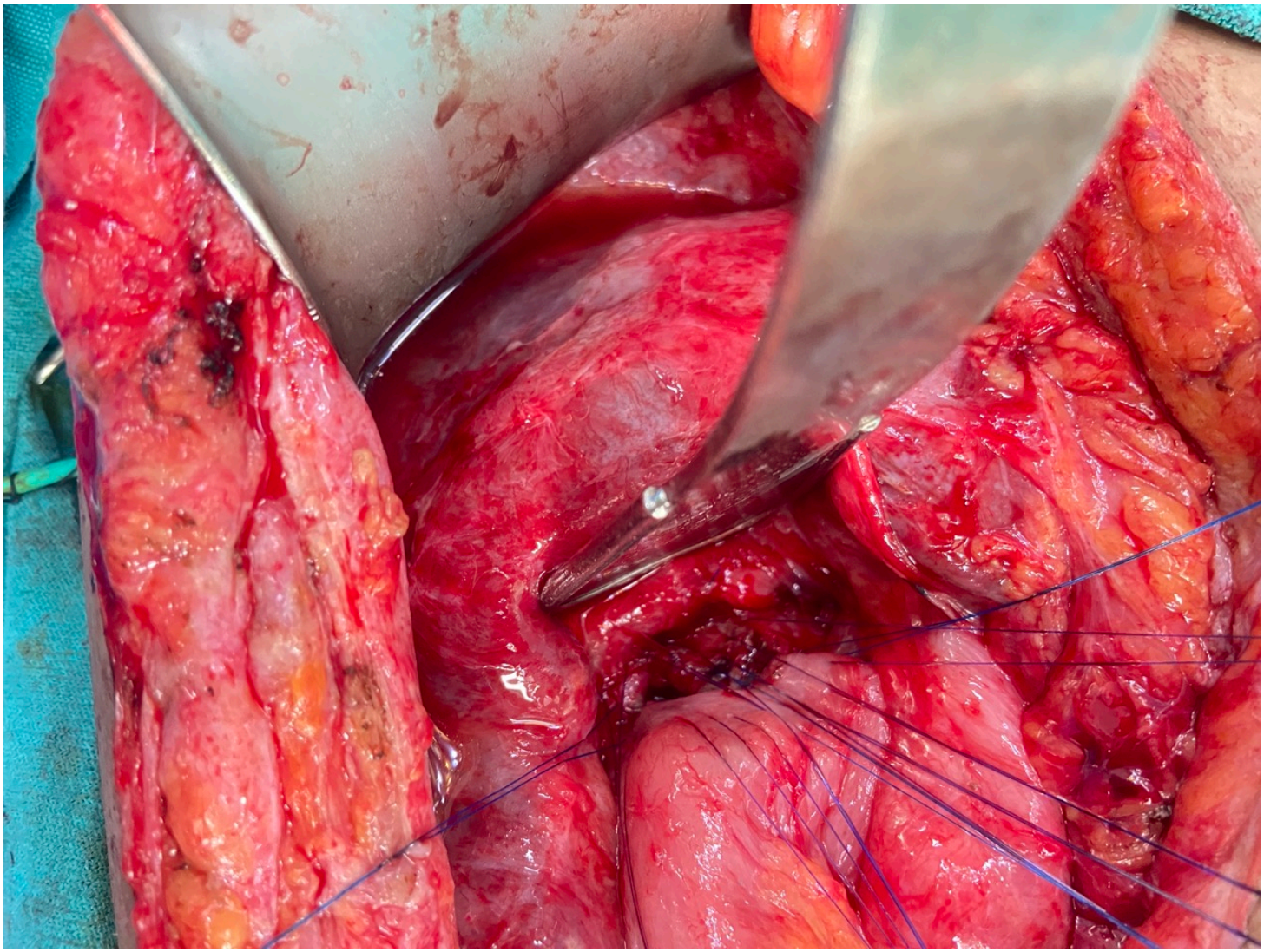
Introduction:
In patients of post cholecystectomy benign biliary strictures (BBS), Portal hypertension (PHT) and secondary biliary cirrhosis (SBC) can lead to increased morbidity and mortality. We analysed factors responsible, peri-operative management and long-term outcomes.

Material and Method:
Prospective database of BBS (15 year) was analyzed. Preoperative, intra-operative and peri-operative parameters in patients with or without PHT were compared. McDonald grading used for long-term outcomes

Results:
Study included 613 patients of BBS. 19 patients had PHT associated more with higher grade of BBS [III (n=12,63%) $p < 0.01$]. Median time to repair was more than four times longer (826 days vs. 210 days, $p< 0.01$) than those without PHT. Failed previous repair seen in 3 patients of PHT. RYHJ with a liver biopsy was performed in all patients. Hepatic resection (HR) or porto-systemic shunting was not required. Significantly increased mean operating time (4.6 ± 2.8 vs. 3.5 ± 2 hours, $p= 0.65$) and median blood loss (400 ml vs. 200 ml) was seen in patients with PHT without significant increase in morbidity. Cirrhosis was found in histopathology in 14 patients (72%). Median follow up time was 54 months with long term success rate for RYHJ as 89% and revision RYHJ was required in only 1 patient.

Conclusion:
Factors associated with SBC and PHT in patients of BBS were delayed repair, higher grade and failed primary repair. With meticulous approach RYHJ is possible in these patients with excellent long-term results.





ISW26-351-05 (0915)

PREDICTING DIFFICULT LAPAROSCOPIC CHOLECYSTECTOMY USING THE PARKLAND GRADING: AN OBSERVATIONAL STUDY IN A TERTIARY CENTER IN EASTERN UTTAR PRADESH, INDIA.

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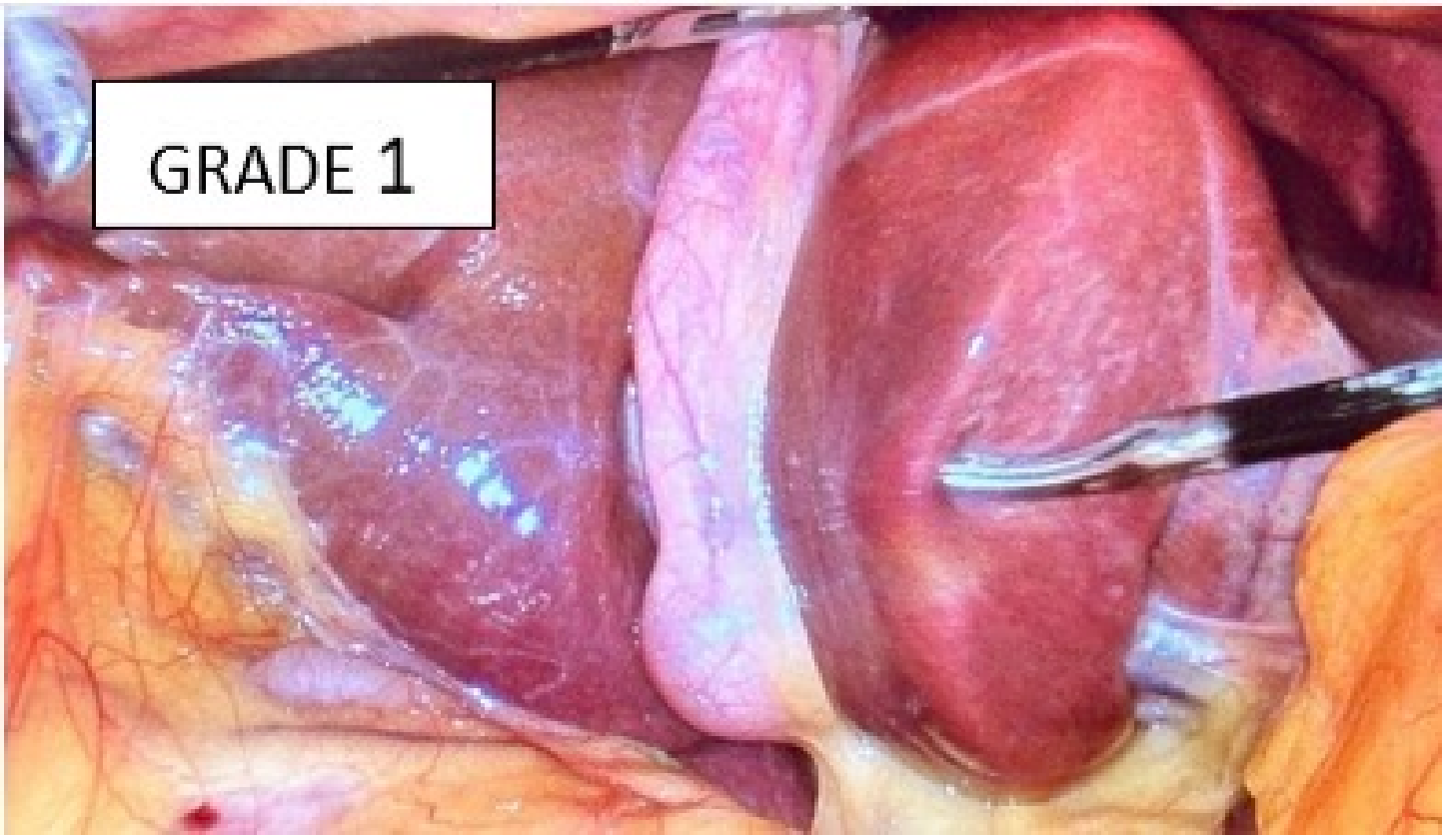
Introduction:
Laparoscopic cholecystectomy is the gold standard for treating symptomatic gallstones, but surgical difficulty can vary. This study aimed to identify if intra-operative factors could predict a difficult procedure by giving them an objective intra-operative Parkland grading scale.

Material and Method:
This prospective observational study involved 44 patients undergoing laparoscopic cholecystectomy. Pre-operative demographic, clinical, and radiological data were collected. During surgery, the difficulty was assessed using the five-point Parkland grading scale. These findings were then analysed against operative time, post-operative stay, and conversion rates. The chi-squared test was used to determine the statistical significance of these associations.

Results:
A higher Parkland grade strongly correlated with increased surgical difficulty. Key intra-operative findings showed a significant association with higher grades: adhesions (p=0.0083), an impacted stone (p=0.0100), hyperemia (p=0.0477), and pericholecystic fluid (p=0.0228). Higher grades were directly linked to longer operative times and an increased risk of conversion to open surgery. Notably, the single case converted to an open procedure and two abandoned procedures were all classified as Parkland grade 5. Pre-operative factors such as BMI and a history of previous surgery did not show a significant correlation in this cohort.

Conclusion:
The Parkland grading scale is a reliable measure of intra-operative difficulty in laparoscopic cholecystectomy. The presence of adhesions, impacted stones, and signs of acute inflammation are significant predictors of a more complex and prolonged surgery, highlighting their importance in pre-operative risk assessment.


GRADE 1


GRADE 5

ISW26-351-06 (0891)

LONG TERM SEX REALTED QUALITY OF LIFE AND HEALTH RELATED QUALITY OF LIFE IN PATIENT UNDERGOING TEP AND OPEN HERNIA REPAIR

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Introduction:
Chronic pain as a result of hernia surgery is well-recognized.Knowledge of impairment of sexual function due to pain caused by an inguinal hernia or a postoperative chronic pain condition is, however, limited. Pain affecting sexual function after hernia surgery is believed to be caused by nerve injury, and inflammation around the mesh or its fixation. It can lead to impaired sexual function and quality-of-life.

Material and Method:
A prospective observational study was conducted involving patients who underwent either TEP or open mesh hernioplasty. Participants were evaluated at baseline and followed up postoperatively at day 7th,30th and 180th day and 1year. Validated questionnaires incuding the SexIHQ, Inguinal pain questionnaire and SF36 scale to evaluate the sexual and overall quality of life in these patients.

Results:
A total of 90 operations consisting of 45 TEP and 45 LH repairs were evaluated. While both groups showed improvements in HRQoL, the TEP group had significant improvements in early postoperative recovery, lower incidence of chronic pain. In terms of SRQoL, TEP patients reported earlier resumption of sexual activity and lower incidence of sexual complications.

Conclusion:
TEP repair yields better results than the LH repair in the postoperative course at the 7th and 30th day evaluation, concerning sexual function and quality of life, but this benefit is no longer apparent at the 90th day. These findings support the preferential use of the laparoscopic approach in suitable candidates, not only for physical recovery but also for preserving sexual function and overall well-being.

ISW26-351-07 (0542)

SURGICAL MANAGEMENT OF NON-HEPATIC MALIGNANCY IN CIRRHOTIC PATIENTS: PERSPECTIVE BEYOND NIHILISM!!

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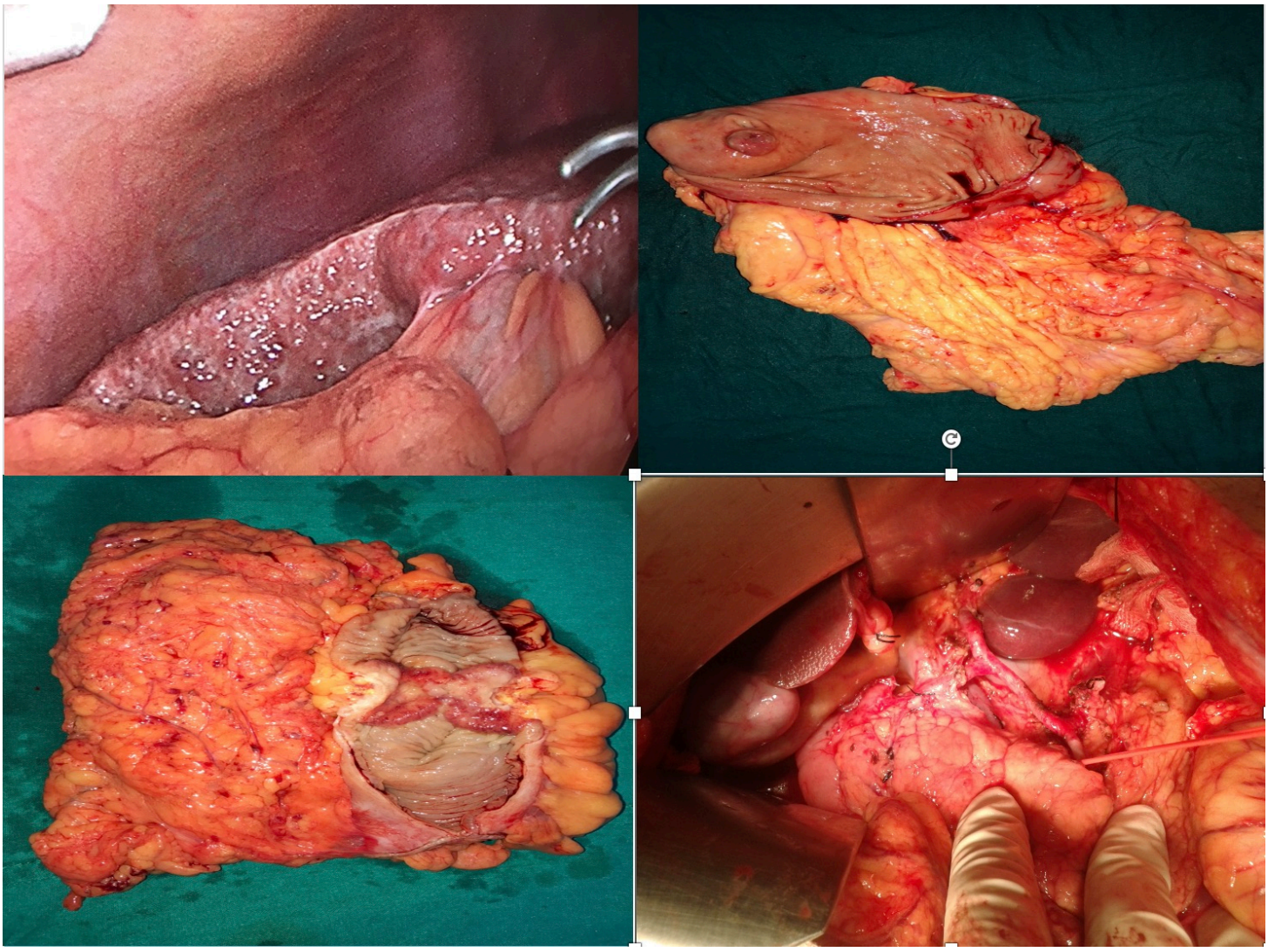
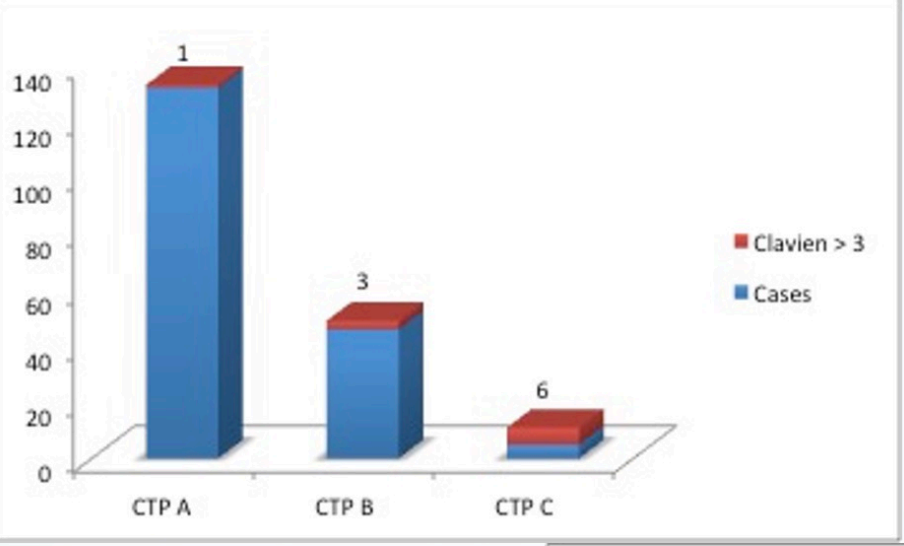
Introduction:
A nihilistic view for surgery in cirrhotic patients with non-hepatic malignancy (NHM) is usually presented due to high mortality rates of up to 25%. We try to present a positive perspective in management of these patients.

Material and Method:
Analysis of data of patients with cirrhosis with NHM who underwent surgery during period of January 2019 to December 2024 was done. Child Turcot Pugh (CTP) and Model for End stage Liver Disease (MELD) scores, intraoperative parameters, perioperative morbidity (Clavien Dindo classification), mortality and hospital stay were included in the analysis.

Results:
Study included 50 patients of cirrhosis undergoing surgery for NHM including colorectal, upper GI and periampullary malignancy. Emergency surgery was done in 6 patients. CTP grade A, B & C were present in 26 patients,13 patients and 11 patients respectively. Mean MELD score was 9.5 ± 4.2. Mean operating time was 4.6 ± 2.4 hours and mean blood loss of 305 ± 150 ml. Median blood transfusion requirement was 2 (1-5) PRBC. Overall morbidity was 26% but major morbidity (Clavien Dindo > 3) seen in 5 patients (12.5%) only. Perioperative mortality occurred in 2 patients (5%) with CTP grade C. Median hospital stay was 14 (7-28) days. Emergency surgery had more morbidity (n=2,33%) and mortality (n=1,16%) (p=<0.001).

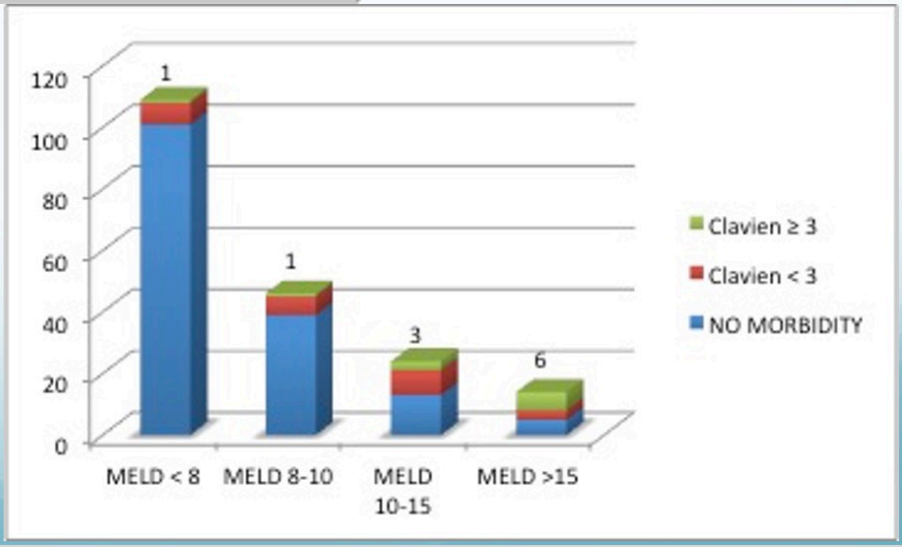
Conclusion:
Emergency surgery, higher CTP grade and higher MELD score is associated with poor outcomes in cirrhotic patients undergoing surgery for non-hepatic malignancy. Meticulous perioperative management leads to excellent results and we need to shun nihilistic attitude for these patients





Morbidity with CTP class

Morbidity & MELD score



ISW26-351-08 (0209)

MIRIZZI SYNDROME: A CHALLENGING DIAGNOSIS. CASE REPORT

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Introduction:
Mirizzi syndrome is an uncommon side effect of gallstones. It is a challenging disorder to diagnose and treat, which presents a unique "challenge" for hepatobiliary surgeons

Material and Method:
A 72-year-old female presented with chronic intermittent right upper quadrant pain associated with bilious vomiting. There was progressive jaundice associated with dark urine but no pruritus nor pale stools. Labs showed leukocytosis and cholestatic picture. CT and MRCP done suggested calculous cholecystitis and obstructive choledocholithiasis. Biliary stenting and stone extraction were done via ERCP and scheduled for laparoscopic cholecystectomy few weeks later after a course of antibiotics. Intraoperatively, extensive adhesions, a cholecystoduodenal fistula, an impacted cystic duct stone and Strasberg A injury prompted conversion to an open procedure. A diagnosis of type 5 Mirizzi syndrome was made. She then benefitted from subtotal cholecystectomy, modified Cellan-Jones repair for duodenal fistula, primary repair of the cystic duct leak and the massive stones were removed. A drain was left in-situ for 10 days, was discharged and is doing well on follow up.

Results:
The significance of this disease stems from the technical challenge of locating the cystic duct during cholecystectomy, increasing the likelihood of bile duct injury (about 17%), therefore a preoperative diagnosis is crucial. ERCP the gold standard for diagnosis has a diagnostic accuracy between 55-90%

Conclusion:
Preoperative diagnosis though crucial to avoid complications is relatively difficult to make. Combining imaging tests is recommended for adequate management. Clinicians should have a high index of suspicion.

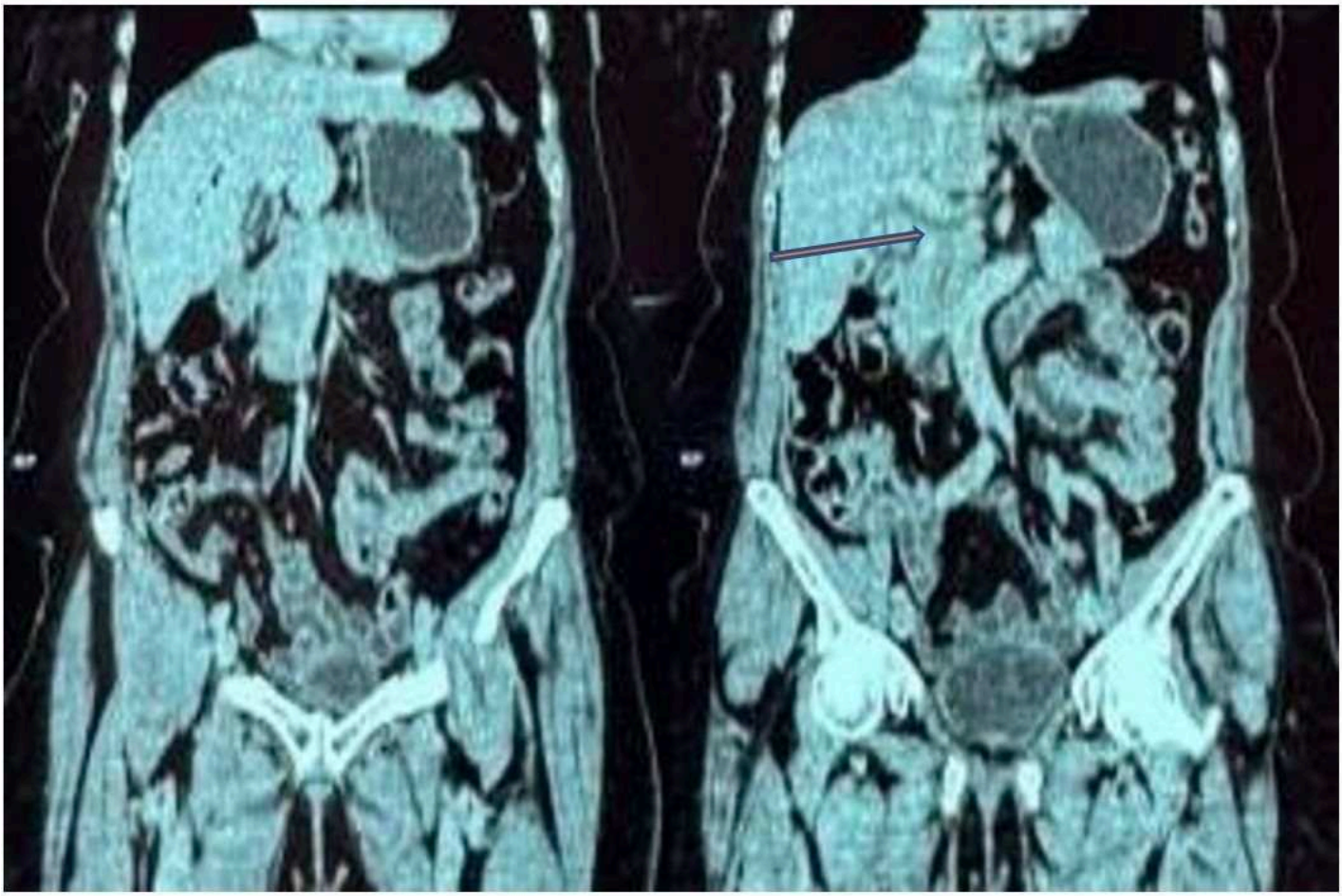
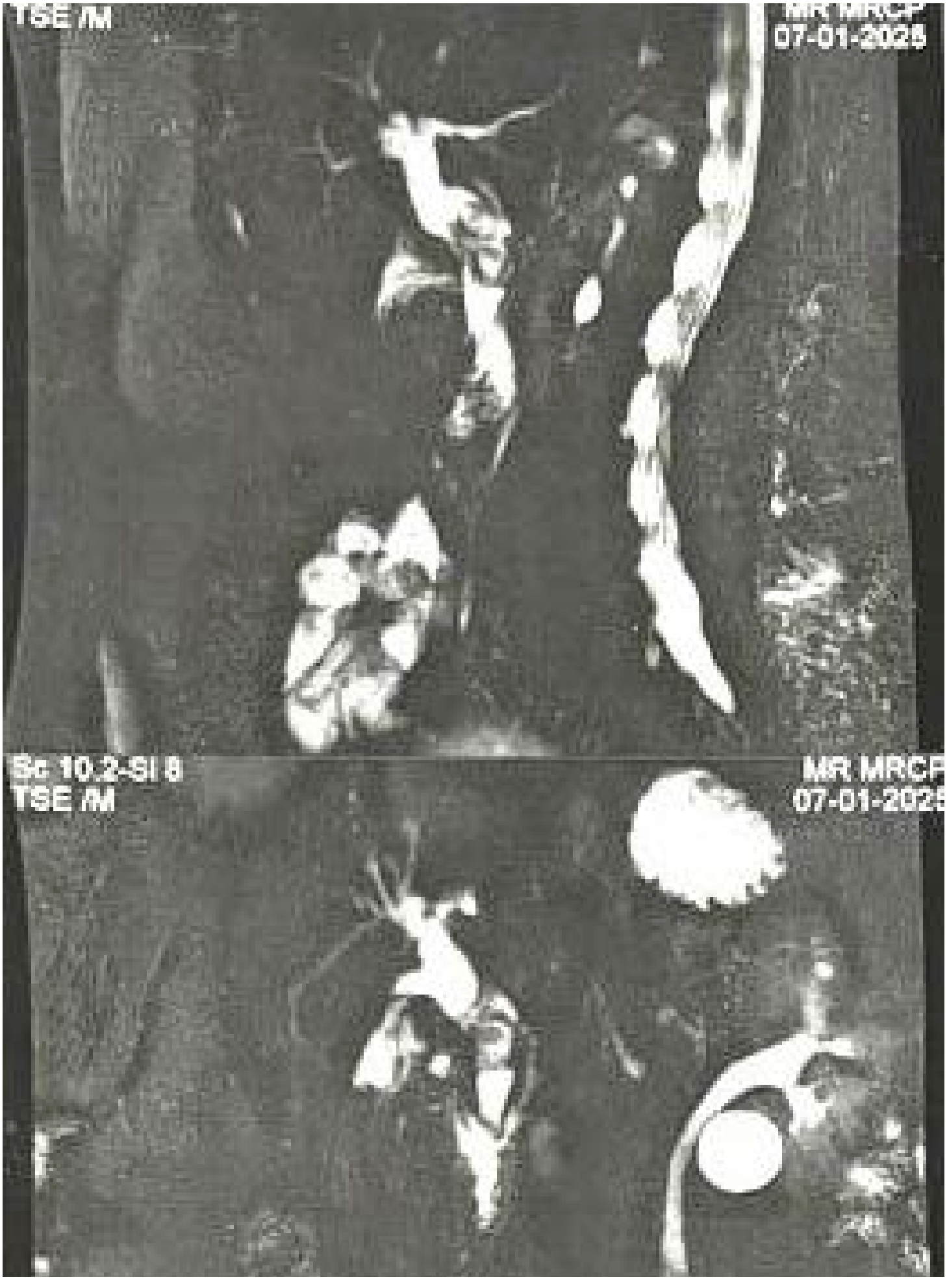


Figure 1 : CT scan images showing dilated CBD. Arrow shows the dilated duct.


TSE /M
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