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<http://www.pediatricurologycasereports.com>**The surgical treatment of stones in the common bile duct and the gallbladder together****Marina Chibisova\****Department of Pediatric Urology, Sechenov University, Moscow, Russia*✉ **Marina Chibisova***Department of Pediatric Urology, Sechenov University, Moscow, Russia**E-mail: Chibisovana@yandex.ru*

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**Description**

Over the past 20 to 30 years, there has been a significant change in how gall bladder and Common Bile Duct (CBD) stones are managed. If any Common Bile Duct (CBD) stones were found during cholangiography, Open Common Duct Exploration (OCBDE), a form of open surgery, would be carried out. Endoscopic Retrograde Cholangiopancreatography (ERCP), which was first developed and quickly adopted, replaced OCBDE as the treatment of choice for ERCP failure.

It is reported that report ductal clearance rates that are comparable to those in these other studies, the variation in success within the Laparoscopic Common Bile Duct Exploration (LCBDE) group. As compared to transcystic CBDEs, which only achieved an 82% ductal clearance rate, choledochotomy and choledochoscopy-performed CBDEs had a ductal clearance rate of 85%. Furthermore, it was observed that 32% of transcystic explorations within the primary Transcystic duct CBD exploration Transcystic Laparoscopic Common Bile Duct Exploration (TC-CBDE) group fail as a result of an inability to navigate the cystic duct, necessitating conversion to choledochotomy.

These findings are especially important because TC-CBDE is frequently viewed as an easier option by surgeons with less training in LCBDE. Therefore, they must be ready to decide whether to proceed with OCBDE, laparoscopic common bile duct exploration choledochotomy, and choledochoscopy, or to stop and schedule a postoperative ERCP. This operational decision-making can be made easier with the help of preoperative investigation using Magnetic Resonance Cholangiopancreatography (MRCP), which can also provide information about whether choledochotomy is necessary.

The size of the stone, the number of ductal stones, and the presence of any distal CBD stricture are among the radiological criteria for a choledochotomy. ERCP may be a better treatment option for a patient who has a single, small stone in a CBD that is largely undilated. However, this will depend on the level of local expertise. Patients in between these two examples can be managed in either manner. Low insertions and long, tortuous cystic ducts will probably make TC-CBDE difficult, if not impossible. Similar to this, it will be challenging and time-consuming to remove multiple small stones from a nondilated CBD using TC-CBDE, and there is a significant risk of pushing some of the stones into the proximal CBD, where they cannot be removed.

The best way to confirm ductal clearance is with choledochoscopy following choledochotomy and a completion cholangiogram following TC-CBDE. Despite these precautions, it is still possible to “miss” stones, although it is likely that for the purposes of this study, the majority will have been represented and taken into account in overall analysis. The records of all patients in the series thanks to the electronic patient

record system currently in use in the area to determine whether or not they had been readmitted with new issues caused by retained stones in any of the three hospitals in the area.

The most worrisome of the early complications may be considered a postoperative bile leak following choledochotomy. The unit is similar to other units in that T-tubes are rarely used, and a drain is frequently left next to the choledochotomy site.

There were no CBD strictures in this study, despite the fact that they are frequently thought to be the most worrisome of potential late complications. It is highly unlikely that any patient developed a stricture without the knowledge given that the regional and national

hepatobiliary services are located within the hospital.

### **Conclusion**

A variety of skills and knowledge are necessary for the effective management of choledocholithiasis. Single-stage laparoscopic surgery can result in ductal clearance rates that are comparable to those obtained using a two-stage approach, but for the best outcomes, the surgeon will need to have experience and optimise the patient flow. Pre-operative imaging with MRCP is helpful in identifying patients in whom a choledochotomy may be necessary, even though TC-CBDE is a useful technique with a low morbidity and a high failure rate. This may then be useful in deciding on the surgeon and the kind of surgery.