

CRITERIA FOR ASSESSING IMMEDIATE AND LONG-TERM RESULTS OF LAPAROSCOPIC CHOLECYSTECTOMY

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Relevance. In cases of high surgical and anesthetic risk due to the underlying condition (perivesical infiltrate, cholangitis) and associated pathology, treatment is performed in two stages. During the first stage (1-2 days), percutaneous cholecystostomy and endoscopic papillotomy are performed. During the second stage, after the patient's condition has improved and the risk has decreased, cholecystectomy is performed through a mini-incision.

Keywords: laparoscopic cholecystectomy, endoscopic papillotomy.

Abstract. The high prevalence of cholelithiasis, the increase in the number of elderly and senile patients, as well as the widespread concomitant cardiovascular, endocrine and metabolic diseases cause a steady increase in the number of patients with complicated forms of gallbladder inflammation, as written in their work by scientists from Uzbekistan [1,3,5,7,9,11,13], representing the Bukhara State Medical Institute, and they noted that the presence of multiple concomitant pathologies, a decrease in the functional reserves of the body and a high frequency of complicated forms of the disease significantly complicate both the diagnostic process and the decision-making process on choosing the optimal method of surgical treatment, which is also emphasized by Russian scientists, for example, from the Far Eastern State Medical University [2,4,6,8,10] and Novosibirsk National Research State University [3,15,17,19], and employees of the Institute of Postgraduate Education in Healthcare of the Republic of Tajikistan N.D. Mukhiddinov et al. [2,14,16,18] having studied the results of treatment of 95 patients with ACC showed that when choosing surgical tactics it is necessary to take into account not only the form of the inflammatory process, but also the nature of local anatomical changes, and when analyzing the results of open interventions, complications of the early postoperative period were recorded in 22.5% of patients, and the mortality rate reached 7.5%, which leads to an increase in publications where LHEC is considered as the main method of surgical treatment of ACC, and the accumulated world experience indicates that the use of minimally invasive technologies can significantly reduce surgical trauma, reduce the duration of hospitalization and reduce the frequency of postoperative complications compared to

traditional interventions, as written by researchers from the Beijing Union Medical College and the Chinese Academy of Medical Sciences Q. Liu et al. [20,21,22,23].

It should be noted that the presented studies focused primarily on the factors that contribute to difficult laparoscopic cholecystectomy, the reasons for access conversion, individual intraoperative complications, and improving the technical aspects of the procedure. However, the patterns of sequential development of unfavorable laparoscopic cholecystectomy outcomes, which integrate clinical, instrumental, and intraoperative changes into a single pathogenetic chain of complications, remain insufficiently studied.

Furthermore, the available literature contains virtually no studies devoted to a comprehensive assessment of preoperative and early intraoperative risk criteria, followed by the use of the obtained data for an objective choice of surgical tactics.

Aim of the study: To improve the results of laparoscopic cholecystectomy for acute calculous cholecystitis by developing and implementing a clinical and instrumental method for predicting the degree of surgical complexity.

Materials and methods. The study was conducted at the Abu Ali Ibn Sina Bukhara State Medical Institute. It analyzed the examination and surgical treatment results for 184 patients with ACC who underwent emergency or urgent laparoscopic cholecystectomy between 2023 and 2026. Depending on the diagnostic and treatment strategy used, all patients were divided into two clinical groups.

Accordingly, the conditions for dividing patients into the control and study groups were based on a comparison of two comparable groups, which formed the basis for a comparative assessment of the results of traditional and improved approaches to surgical treatment of patients with ACC. In accordance with these criteria, we defined study inclusion criteria as patients with a clinically, laboratory, or instrumentally confirmed diagnosis of ACC who underwent emergency or urgent laparoscopic cholecystectomy during hospitalization.

Results of the study and discussion. The immediate results of surgical treatment were analyzed based on the duration of surgery (min), the need for conversion, the nature and frequency of postoperative complications, the duration of postoperative hospitalization, and the total duration of inpatient treatment. All postoperative complications were systematized in accordance with the international Clavien-Dindo classification, which provides for the division of complications depending on their severity and the scope of the necessary therapeutic correction. That is, we classified grade I complications as conditions that do not require special drug or invasive treatment; grade II complications included situations requiring additional drug therapy,

blood transfusion, or other therapeutic measures; grade III complications were those cases characterized by the need for invasive interventions, including puncture-drainage procedures, endoscopic or repeat surgical interventions; grade IV complications corresponded to the development of life-threatening conditions requiring intensive care, while grade V complications included fatal outcomes. To assess the long-term outcomes of surgical treatment, we analyzed clinical manifestations of biliary pathology that developed after patient discharge. We monitored patients for 1 to 3 months postoperatively through outpatient examinations, medical record analysis, and repeat visits to specialized medical care. The main evaluation criteria were the presence of biliary pain syndrome, repeat visits for biliary tract diseases, the development of residual or recurrent choledocholithiasis, cholangitis, extrahepatic bile duct strictures, and the need for repeat endoscopic retrograde cholangiopancreatography or readmission. This analysis included an additional analysis of the cumulative incidence of biliary complications as an integral indicator of the long-term outcomes of surgical treatment.

Conclusions. For successful completion of treatment in patients with persistently high surgical risk after cholecystostomy, complete gallbladder debridement and ablation of its cavity are necessary. This is achieved through endoscopic obliteration of the gallbladder, which is less traumatic and dangerous than cholecystectomy. A contraindication to endoscopic obliteration of the gallbladder is unresolved common bile duct obstruction. The obtained results allow endoscopic obliteration of the gallbladder to be considered as an alternative to cholecystectomy and conservative treatment of acute cholecystitis in patients with severe comorbidities.

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