CHOLEDOCHAL CYST

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SUMMARY

A review of 29 cases of Choledochal Cyst is presented in this paper. Twenty six cases were operated in Paediatric Surgery Unit, Lady Reading Hospital Peshawar. Two patients admitted as mass abdomen once diagnosed did not turn up for surgery. One case admitted as septicemia died pre-operatively. There were 20 female and 9 male children with ratio of 3.2 : 1. The age of presentation was 22 days to 14.5 years. The commonest way of management was total cyst excision with Hepaticojejunostomy with Roux-N-Y Jejunojejenostomy. The other method was Cystojejenostomy with Roux-N-Y Jejunojejenostomy.

INTRODUCTION

Cystic dilatation of common bile duct is a rare anomaly but due to improvement and easy availability of ultrasound in periphery, it is being frequently diagnosed.

The condition can be classified in seven types, based on investigations like ERCP and HIDA. More than 90% of cases can be classified as of more than 90% of cases.[1] The presentation is mainly in two forms. In neonatal form, which occurs in less than 2 years of age with jaundice and Hepatomegaly, while adult type present as pain and mass abdomen.

MATERIAL AND METHODS

Between February, 1990 to July, 1996 twenty nine cases of Choledochal cysts presented to Paediatric Surgery unit, Lady Reading Hospital Peshawar.[4] 25% of the cases were from Afghan Refugees 68.9% female and 21.1% as male cases. There were 3 neonates (less than one month age) in this series.

Twenty four cases were Type-I and two cases were Type-II in nature. The commonest mode of presentation was pain abdomen followed by jaundice in 14 cases and mass abdomen in 12 cases. Two cases presented as Ascites abdomen and two as Acute abdomen mimicking peritonitis.

Ultrasound abdomen was main tool of diagnosis. CT scan was done in two cases where ultrasound was doubtful.

In 16 cases total excision of cysts with Choledochojejunostomy with Roux-N-Y jejenojejunostomy was performed. Cysto-jejunostomy with Roux-N-Y Jejenoje-junostomy was performed in cases of Ascites, Cirrhosis Liver, massive size cysts and cases with Acute abdomen operated in emergency. Partial excision of cyst with mucosal strapping was performed in two cases with adhesion and fibrosis.

RESULTS

Four patients died post-operatively. Two cases had Cirrhosis Liver, one of the patient had haematemisis due to oesophageal varices. One case operated in emergency died and the another case died after developing post-operative Septicemia.

One case developed post-operative leak, which improved on conservative treatment after 3 weeks.

Two cases presented with pain abdomen after second and third year of surgery with sub-acute adhesion obstruction improved on conservative treatment.

DISCUSSION

Various operations have been performed in the past like Aspirations, Tube drainage, Open drainage, Choledochoduodenostomy. All these had high morbidity and more than 80% had delayed complications. The best way of managing these cases is total excision with hepatico-jejunostomy with Roux-N-Y Jejenojejunostomy with less than 7% of complication rate.[2] Second best procedure is Cystojejunostomy with Roux-N-Y jejenojejenostomy.[3]

We performed total cyst excision with Choledochojejunostomy with Roux-N-Y Jejenojejunostomy in 16 cases. Some of these cysts were of enormous size. With the passage of time and increase in our experience with these cases, excision of big size of the cyst was not a problem, provided that there were no adhesions and fibrosis due to previous infections.

Cystojejunostomy with Roux-N-Y jejenojejenostomy was performed in 10 cases but all these cases were complicated ones. Two cases each of Ruptured Choledochal cysts, Cirrhosis liver, thick adhesion and fibrosis; and two cases being operated in emergency for Peritonitis with prior ultrasound diagnosis were seriously ill patients. Total excision in these cases would have lead to much more morbidity and mortality.

Yeong et al reported regression of biliary Cirrhosis after Choledochal cysts drainage.[6] In our series, the two cases of Cirrhosis did not survive. One of the case was neonate of 22 days and the other one 3 years baby developing Haemetemesis needing 4 units of blood had probably varices. Both the cases were not diagnosed as having Cirrhosis prior to surgery.

More efforts are needed to diagnose cases of Cirrhosis and further investigations to know about the complications of Cirrhosis like Portal Hypertension and varices. To perform surgery in neonatal age and in advance Cirrhosis with complications need second thought before making any decision for extensive surgery.

As far as new classification of Choledochal cysts is concerned, we had two cases of Type-II i.e. Supraduodenal cystic dilatation with no communication to the duodenum. It supports the obstructive nature of disease although these cases were not followed from antenatal age.[5]

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