62° Congreso Uruguayo DE CIRUGIA

XXII Jornadas de Residentes de Cirugía General
XXI Jornadas Integradas de Enfermería Quirúrgica
XX Jornadas Integradas de Instrumentación Quirúrgica
Curso precongreso: Cirugía laparoscópica avanzada.

23 al 26 de Noviembre del 2011 – Centro de Convenciones de la Intendencia de Montevideo, Uruguay

TRATAMIENTO DE LA COLANGITIS AGUDA

CLINICA QUIRÚRGICA "B"

Hospital de Clínicas

Dr. Joaquín Pereyra

INTRODUCCIÓN

- Se define como la infección de la vía biliar principal.
- Habitualmente secundaria a la litiasis coledociana
- Primera descripción realizada por Charcot 1877 “fiebre hepática”
- Se presenta en un 6 a 9 % de los pacientes que presentan litiasis vesicular

INTRODUCCIÓN

- Evolución impredecible
- Rápidamente progresiva en anciano
- Métodos diagnósticos y terapéuticos han mejorado pronóstico.
- Mortalidad mayor al 50% antes de los años 70 a menos del 7% en los 80 *

* Mosler P, Diagnosis and Management of acute cholangitis. Curr gastroenterol.Rep (2011)13:166-172

ETIOPATOGENIA

- 2 componentes
  - Obstrucción total o parcial
    - LITIASIS
    - Estenosis benignas o malignas
    - Parásitos
    - Otras (stent, diverticulos)
  - Infección
    - Colonización Bacteriana
    - Polimicrobiana
    - Mas cultivos positivos en obstrucciones parciales

- Con posterior aumento de presión intraductal con reflujo

DIAGNÓSTICO

- Clásica tríada de Charcot
- Presente en menos del 50- 70%
- Bajo rendimiento diagnóstico
  - Necesidad de estandarizar el diagnostico

J Hepatobiliary Pancreat Surg (2007) 14:11–14
DOI 10.1007/s00534-006-1151-z

Journal of HBP Surgery

Need for criteria for the diagnosis and severity assessment of acute cholangitis and cholecystitis: Tokyo Guidelines

Miho Sekimoto[1], Tadahiro Takada[2], Yoshifumi Kawarada[3], Y
Toshihiko Mayumi[5], Fumihiko Miura[2], Keita Wada[2], Masahik
Henry A. Pitt[9], Jacques Belghiti[10], Eduardo de Santibanes[11],
Sun-Whe Kim[14], Kui-Hin Liau[15], Sheung-Tat Fan[16], Giulio Bei

Table 2 Tokyo Guidelines diagnostic criteria for acute cholangitis

A. Clinical context and clinical manifestations

1. History of biliary disease
2. Fever and/or chills
3. Jaundice
4. Abdominal pain (RUQ or upper abdominal)

B. Laboratory data

5. Evidence of inflammatory response (abnormal WBC count, increased serum CRP level, and other changes indicating inflammation)
6. Abnormal liver function tests [Increased serum ALP, γ-GTP (GGT), AST, and ALT levels]

C. Imaging findings

7. Biliary dilatation or evidence of an etiology (stricture, stone, stent, etc.)

Suspected diagnosis

Two or more items in A

Definite diagnosis

① Charcot's triad (2 + 3 + 4)

② Two or more items in A + both items in B and item C

J Hepatobiliary Pancreat Sci (2011) 18:250–257
DOI 10.1007/s00534-010-0338-5

ORIGINAL ARTICLE

Accuracy of the Tokyo Guidelines for the diagnosis of acute cholangitis and cholecystitis taking into consideration the clinical practice pattern in Japan

Masamichi Yokoe · Tadahiro Takada · Toshihiko Mayumi · Masahiro Yoshida · Hiroshi Hasegawa · Shinji Norimizu · Katsumi Hayashi · Shuichiro Umemura · Etsuro Orito

Published online: 3 November 2010

Conclusion

We evaluated the diagnostic accuracy of the Tokyo Guidelines for acute cholangitis and cholecystitis. The sensitivity and specificity of the guidelines for the diagnosis of acute cholangitis were not high enough to allow us to make either a definitive diagnosis or a rule-out diagnosis. While the sensitivity for the diagnosis of acute cholecystis was relatively high, the specificity was low. The diagnostic accuracy of the Tokyo Guidelines was significantly higher than that based on Charcot's triad for acute cholangitis or Murphy's sign for acute cholecystitis. It was therefore concluded that the Tokyo Guidelines should be more widely used for the diagnosis of acute cholangitis and cholecystitis in the twenty-first century.

by the 2009 Sciences Research Grants program of the Japanese Ministry of Health, Labour, and Welfare.

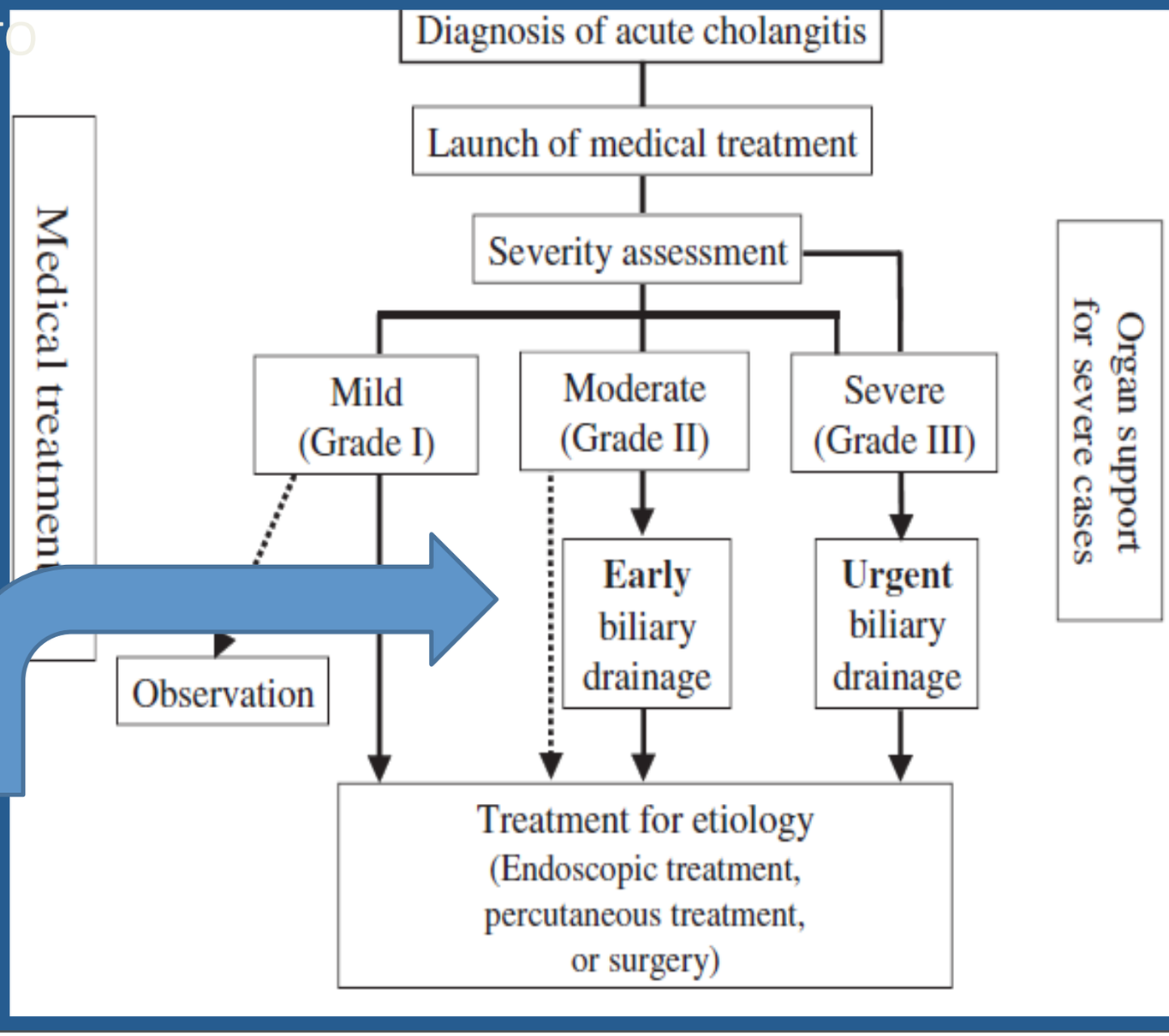
MÉTODOS DIAGNÓSTICOS

Transabdominal ultrasound	Readily available, noninvasive, inexpensive	Low sensitivity for choledocholithiasis (25%–63%) and etiology of biliary obstruction
	High sensitivity for detection of gallbladder stones and biliary dilation	Operator dependent
CT	Noninvasive	No therapeutic capability or tissue acquisition in suspected malignancy
	Higher sensitivity for detecting location of obstruction and underlying etiology, including neoplasms	Radiation risk
		Contrast media may be required (nephrotoxicity, allergies)
		Low sensitivity only for cholelithiasis
MRCP	Noninvasive, no radiation risk, safe in pregnancy	No therapeutic capability
	High sensitivity for biliary obstruction and detection of bile duct stones >6 mm	No tissue acquisition in suspected malignancy
	Can be combined with abdominal MRI and thereby adopt advantages of CT at same time	Not possible in patients with ferromagnetic implants or severe claustrophobia
EUS	High sensitivity for large and small bile duct stones and pancreaticobiliary malignancy	Limited availability
	Can establish tissue diagnosis	More invasive
	Can be combined with ERCP	Operator dependent
ERCP	Provides biliary drainage	Invasive, potential for procedure-related complications
	High sensitivity for location of biliary obstruction	Problematic if complete biliary drainage fails
	Tissue acquisition in suspected malignancy possible	Operator dependent
PTC	Provides biliary drainage	Invasive, potential for procedure-related complications
	High sensitivity for location of biliary obstruction	Limited in case of coagulopathy
		Higher complication rate and more patient discomfort compared to ERCP
		Operator dependent

CLASIFICACIÓN

GUÍAS DE TOKIO. SE BASA EN EL CONTROL CLÍNICO. SON ESENCIALES LAS PRIMERAS 24 HORAS Y EL COMIENZO DEL TRATAMIENTO MÉDICO

VARIABLE TIEMPO



TRATAMIENTO

- ESCENARIO

  – Paciente operable por su terreno, que una vez instituido el tratamiento medico, no mejora y mantiene su colangitis. Sin disfunciones

TRATAMIENTO

- INICIO
- Tratamiento medico
  - Reposición
  - Analgesia
  - Antibióticos
    - Leves penicilinas/inhibidor de betalactamasas. Piperacilina/ Tazobactam o Ampicilina-sulbactam. Tratamiento por 3 días
    - Severas cefalosporinas de 3 o 4 generación, penicilinas/inhibidor betalactamasas, pudiendo asociarse Fluorquinolonas o Carbapenems. Por 5-7 días.

      (según JPN Tokio guidelines)

TRATAMIENTO

- ARSENAL TERAPEÚTICO

  –CPER seguido de colecistectomía LP

  –Laparoendoscopía intraoperatoria “rendez-vous”

  –Tratamiento integral laparoscópico

  –Cirugía laparotómica

Cirugía en diferido de la litiasis coledociana impactada: menor porcentaje de intervención sobre la vía biliar

Carlos Acevedo Fernando Mandirola y Marcelo Teixeira
Clínica Quirúrgica A. Hospital de Clínicas Manuel Quintela. Montevideo. Uruguay.

Conclusiones. Los resultados de nuestro estudio indican que la cirugía diferida de la litiasis coledociana impactada disminuye el número de pacientes en los que es necesaria la instrumentación de la vía biliar principal y reduce el número de pacientes con drenaje biliar.

J Hepatobiliary Pancreat Surg (2007) 14:27–34
DOI 10.1007/s00534-006-1153-x

Journal of HBP Surgery

Flowcharts for the diagnosis and treatment of acute cholangitis and cholecystitis: Tokyo Guidelines

Fumihiko Miura[1], Tadahiro Takada[1], Yoshifumi Kawarada[2], Yuji Nimura[3], Keita Wada[1], Masahiko Hirota[4], Masato Nagino[3], Toshio Tsuyuguchi[5], Toshihiko Mayumi[6], Masahiro Yoshida[1], Steven M. Strasberg[7], Henry A. Pitt[8], Jacques Belghiti[9], Eduardo de Santibanes[10], Thomas R. Gadacz[11], Dirk J. Gouma[12], Sheung-Tat Fan[13], Miin-Fu Chen[14], Robert T. Padbury[15], Philippus C. Bornman[16], Sun-Whe Kim[17], Kui-Hin Liau[18], Giulio Belli[19], and Christos Dervenis[20]

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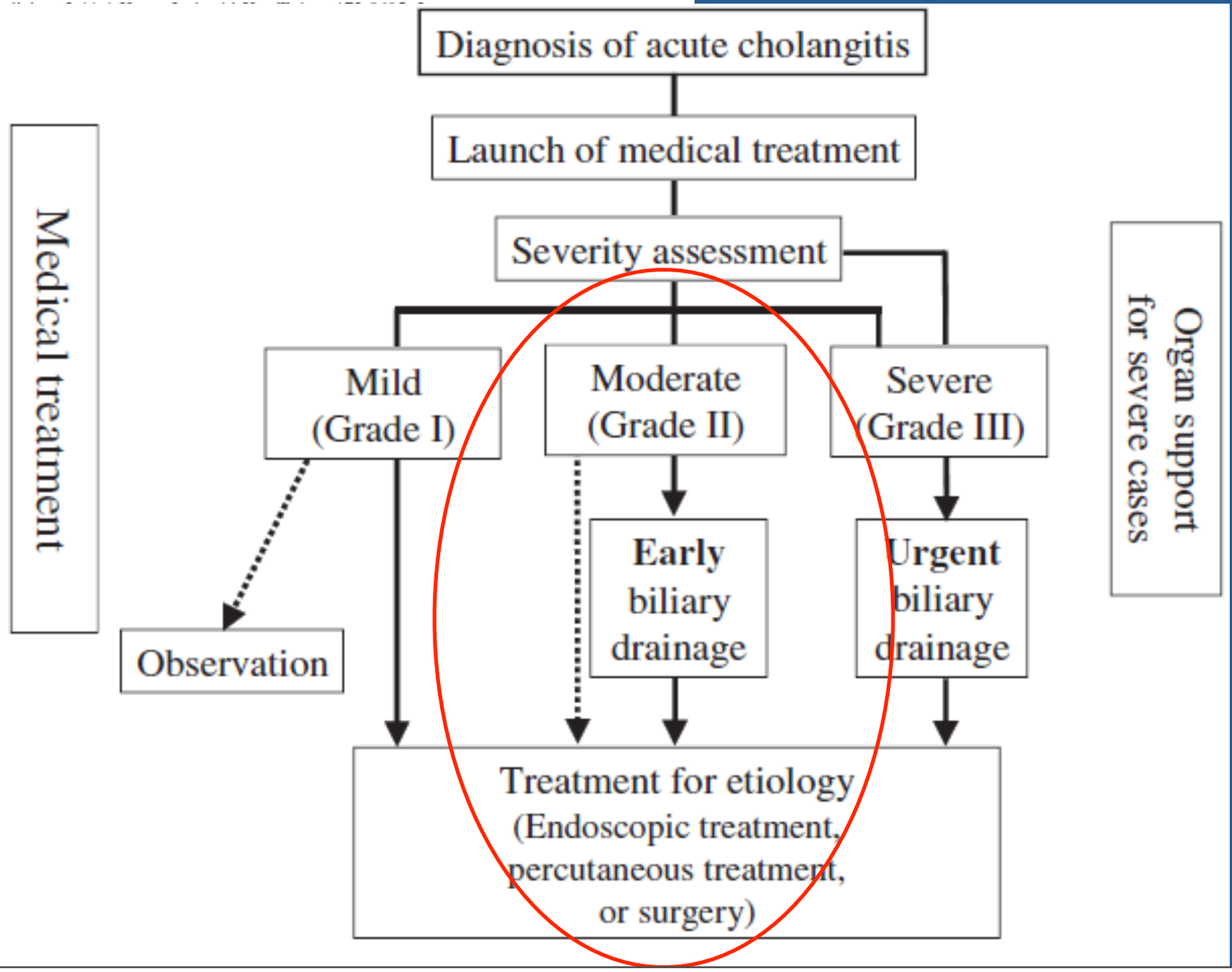

CPER

Surg Endosc (2002) 16: 975–980
DOI: 10.1007/s00464-001-9133-3

SURGICAL ENDOSCOPY
and Other Interventional Techniques

Gallstone cholangitis

A 10-year experience of combined endoscopic and laparoscopic treatment

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LA REALIZACIÓN DE LA CPER SEGUIDA DE ES (PAPILOTOMÍA), ES UNA OPCION EFECTIVA Y SEGURA. LA MISMA DEBE SEGUIRSE DE UNA COLECISTECTOMIA LAPAROSCOPICA, SALVO EN PACIENTES CON RIESGO QUIRURGICO ALTO

CPER

Original Article

Laparoscopic Common Bile Duct Exploration: Our First 50 Cases

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Kui-Hin Liau,[1] *FRCS (Edin), FICS (USA), FAMS*, Chung-Yip Chan,[1] *MD, FRCSEd (Gen), FAMS*, Choon-Kiat Ho,[1] *FRCS (Edin), FRCSEd (Gen), FAMS*

- Ratifican el rol de la CPER para la colangitis.
- Critican el uso sistemático de la CPER por complicaciones y ausencia de garantías en la litiasis coledociana.
- Buena experiencia en la extracción de litiasis de la VBP (6% de litiasis residual)

CPER

CIRUGÍA ESPAÑOLA

ELSEVIER DOYMA

www.elsevier.es/cirugia

Original

Análisis de los factores de conversión durante colecistectomía laparoscópica a abierta en una cohorte prospectiva de 703 pacientes con colecistitis aguda

Tabla 3 – Análisis multivariado de los factores asociados con conversión

Factor	OR	DE	p	IC 95%	
Ictericia	1,241	0,482	0,577	0,580	2,657
Colangitis	1,612	1,153	0,504	0,397	6,549
BT > 2 mg/dl	0,758	0,271	0,44	0,376	1,528
HTA	1,324	0,361	0,302	0,776	2,259
CPRE	2,022	0,833	0,05	0,501	4,536
ASA III/IV	1,422	0,464	0,28	0,750	2,697
Leucocitos > 12.000 mm^3	1,658	0,408	0,04	1,023	2,686
Engrosamiento de la pared de la vesícula	1,556	0,383	0,072	0,960	2,522
Coledocolitiasis	1,016	0,488	0,973	0,396	2,607
Género masculino	1,743	0,427	0,023	1,078	2,817
Edad (18-44 años)	0,4	0,123	0,3	0,218	0,734
Edad (> 70 años)	2,793	0,833	0,001	1,556	5,011

ASA: *American Society of Anaesthesiology*; BT: bilirrubina total; CPRE: colangiopancreatografía retrógrada endoscópica; DE: desviación estándar; HTA: hipertensión arterial; IC: intervalo de confianza; OR: odds ratio.

Table 3 Appropriateness of the different therapeutic procedures for preoperatively diagnosed common bile duct stones

			Patient with cholangitis or sepsis						Patient without cholangitis or sepsis					
			Previous Cholecystectomy			Gallbladder "in situ"			Previous cholecystectomy			Gallbladder "in situ"		
			OS	ERCP	LS	OS	ERCP	LS	OS	ERCP	LS	OS	ERCP	LS
KPS ≤40	Bile-duct dilatation	Single stone	UN	AP	UN	UN	AP	UN	IN	AP	UN	UN	AP	AP
		Multiple stones or > 10mm							UN					
	No bile-duct Dilatation		IN		IN	IN			IN			IN		
KPS >40	Bile-duct Dilatation	Single stone	UN		UN	UN						UN		
		Multiple stones or > 10mm							UN					
	No bile-duct Dilatation					IN			IN					

OS open surgery approach; laparothomic cholecystectomy (when gallbladder is present) and bile duct stone removal, *ERCP* preoperative, intraoperative, or postoperative endoscopic retrograde cholangiopancreatography, including sphincterotomy for bile duct stone clearance, with laparoscopic cholecystectomy if gallbladder is present, *LS* laparoscopic surgery approach; laparoscopic cholecystectomy and choledocholithiasis extraction, *KPS* Karnofsky performance status, *AP* appropriateness of the procedure, *IN* inappropriateness of the procedure, *UN* uncertainty of the appropriateness of the procedure

*Parra-Membrives, P, Díaz-Gomez D, Vilegas-Portero R. Appropriate management of common Bile duct stones: A RAND Corporation/UCLA Appropriateness Method statistical analysis. Surg Endosc (2010) 24:1187-1194.

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		Multiple stones or > 10mm							UN					
	No bile-duct Dilatation					IN			IN					

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OPORTUNIDAD

- CPER aumenta la inflamación local, mas si se hizo papilotomía
- Cuanto mas alejado mayor dificultad en la colecistectomía
- Se recomienda antes de las 6 semanas

The American Journal of Surgery (2010) 200, 483–488

The American Journal of Surgery

Clinical Science

Optimal timing of elective laparoscopic cholecystectomy after acute cholangitis and subsequent clearance of choledocholithiasis

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Jonathan Lau Kai Yum, M.B.B.S., M.R.C.S. (Edin.),
Yuk Pang Yeung, M.B.B.S., F.R.C.S. (Edin.)

CPER INTRAOPERATORIA

- Un solo procedimiento
- Mayor dificultad técnica para el endoscopista (posición del paciente)
- Dificultad en la colecistectomía (insuflación duodenal)
  - Se puede evitar
    - Clampeo duodenal
    - Realizar la colecistectomía previo al pasaje de la guía
    - Asistencia a través de guía

EXCLUSIVAMENTE LAPAROSCÓPICO

- Único procedimiento
- Mayor tiempo quirúrgico
- Asociado a mayores complicaciones
- Mayor índice de conversión

ABORDAJE LAPAROTÓMICO

- Aún tiene sus indicaciones
- Asociado a mayor índice de complicaciones, parietales
- Utilidad frente al fracaso de los mecanismos anteriores.

Conclusiones

- Hay evidencia suficiente que para la colangitis que no retrocede la combinación de CPER + LP (en diferido) es la mejor opción
  - Es segura
  - Presenta menor tiempo de colecistectomía
  - Requiere 2 procedimientos
  - Es mas costoso
  - Luego de 24-48 hs de tratamiento médico
  - Colecistectomía lo antes posible, para evitar la inflamación local

CONCLUSIONES

- Igualmente no hay un algoritmo único de tratamiento .
- Se deben tener en cuenta factores:
  - Dependientes del paciente (comorbilidades)
  - Experiencia del equipo quirúrgico
  - Experiencia endoscopista
- Disponibilidad de material tecnológico y costos

MUCHAS GRACIAS