

Comparison of Early and Late Laparoscopic Cholecystectomy Results in the Treatment of Mild and Moderate Acute Biliary Pancreatitis

 Ahmet Başkent,¹  Ebral Yiğit,²  Murat Alkan¹

¹Department of General Surgery,
Kartal Dr. Lütfi Kırdar City Hospital,
İstanbul, Türkiye

²Department of General Surgery,
Diyarbakır Dr. Gazi Yaşargil
Training and Research Hospital,
Diyarbakır, Türkiye

Submitted: 08.02.2022
Accepted: 23.03.2022

Correspondence: Ahmet Başkent,
Kartal Dr. Lütfi Kırdar Şehir
Hastanesi Genel Cerrahi Kliniği,
İstanbul, Türkiye
E-mail: abaskent@gmail.com



Keywords: Acute biliary pancreatitis; delayed cholecystectomy; early cholecystectomy.



This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

ABSTRACT

Objective: Acute pancreatitis is a nonbacterial inflammation that occurs as a result of the pancreatic gland being released into the interstitial area with the activation of its own enzymes and digesting its own tissue. Gallstones are the most common cause of acute pancreatitis. Cholecystectomy is the gold standard in the treatment of acute biliary pancreatitis (ABP) to prevent complications and recurrences. The timing of cholecystectomy is still controversial. In this study, we aimed to compare the early and late results of patients who were hospitalized in our clinic with the diagnosis of mild and moderate ABP and underwent laparoscopic cholecystectomy (LC).

Methods: The files of 45 patients who were hospitalized with the diagnosis of ABP and underwent LC were reviewed retrospectively. Of the patients, 35 (77.8%) were females and 10 (22.2%) were males. Twenty-two patients who underwent LC after completion of ABP treatment were named Group 1, and patients who were given a 2-month interval after ABP treatment and underwent LC afterward were named Group 2.

Results: There were 22 patients in Group 1 and 23 patients in Group 2. It consisted of a total of 45 patients. The average age of the patients was 56 (26–93) years. The average hospital length of stay was 13.18 days in Group 1 and 8.3 days in Group 2. The mean duration of LC was 57.8 min in Group 1 patients, 45.7 min in Group 2, and a significant difference was found ($p < 0.01$). Postoperative complications were seen in 4 (18.2%) patients in Group 1 and 4 (17.4%) patients in Group 2. Acute pancreatitis was seen again in 1 (4.5%) patient in Group 1 and 2 (8.7%) patients in Group 2.

Conclusion: In the treatment of ABP, although the duration of LC performed in the early period was prolonged, there was no difference in postoperative hospital stay and complications. We believe that early LC should be performed to prevent recurrences and complications that may develop after ABP attacks.

INTRODUCTION

Gallstone pancreatitis accounts for 35%–40% of acute pancreatitis cases worldwide, and it constitutes the majority of acute pancreatitis cases in Türkiye.^[1–4] Pathophysiologically, it is thought that the ampulla of Vater is obstructed by migrating stones. Initial treatment in these patients can be conservative or invasive. Conventional treatment^[5–7] or, recently, laparoscopic surgery^[8–10] is recommended due to high recurrence rates (29%–63%) in patients who have not undergone any intervention. However, there is still no consensus regarding the timing of cholecystectomy in patients with biliary pancreatitis. The aim of this study was to compare the early-term laparoscopic cholecystectomy (LC) performed during the first attack of acute pancreatitis and the interval LC procedures in the treatment of

acute pancreatitis and evaluate their outcomes in terms of postoperative morbidity.

In patients with acute biliary pancreatitis (ABP), in addition to recurrence of ABP, complications related to gallstones, cholecystitis, cholangitis, or biliary colic may also be seen. Therefore, surgery is strongly recommended.^[11,12]

Most recently, at the 2012 Atlanta Symposium, ABP was reclassified as mild, moderate, and severe. In our study, we use the 2012 Atlanta consensus definition. Delaying cholecystectomy for patients with a severe form of acute pancreatitis has been widely accepted and practiced. Whereas in mild and moderate forms of acute pancreatitis, much evidence has shown that cholecystectomy performed at an early stage of the disease is a preferred method of treatment. However, different studies

offer various treatment alternatives for early-stage diseases.^[12,13]

MATERIALS AND METHODS

A total of 45 patients who were admitted to the general surgery clinic of our hospital with the diagnosis of ABP and underwent LC between January 2019 and December 2020 were analyzed retrospectively. The patients were divided into two groups according to the treatment methods applied. Group 1 consisted of patients who underwent early-stage LC performed after clinical improvement during the first pancreatitis attack, and Group 2 comprised patients who were treated medically during the first attack and were planned for elective LC (interval cholecystectomy or late-stage LC) to be performed at least 8 weeks later. The patients were evaluated in terms of age, gender, clinical findings, number of attacks, length of hospital stay, duration of surgery, and preoperative complications. The diagnosis of ABP was made based on the occurrence of acute abdominal pain and tenderness, threefold increase in serum amylase and/or lipase values, and detection of stones in the biliary system on ultrasonography (USG). Considering acute pancreatitis, alcohol-induced pancreatitis, familial hyperlipidemia, drugs, and trauma were determined as exclusion criteria for the study.^[1-4] Patients with gallbladder wall thickness or pericholecystic fluid observed in preoperative imaging tests were considered to be accompanied by acute cholecystitis. The severity of the disease was evaluated by the Ranson scoring system. Mild and moderately severe patients with biliary pancreatitis were classified as having Ranson scores ≤ 3 .^[14,15] Severe pancreatitis with a Ranson score of 4 and above was not included in the study. Clinical improvement was determined as normalization of serum amylase, lipase levels, and liver function test results (if elevated at the beginning) and regression of abdominal pain.

Our study was approved by the ethics committee of our hospital.

Statistical Package for Social Sciences (SPSS) for Windows 13.0 program was used for all statistical analyses in the study. While evaluating the study data, Student's t-test was used for the comparison of normally distributed parameters in comparison to quantitative data as well as descriptive statistical methods (mean, standard deviation, and frequency). The Chi-squared test and Fisher's exact Chi-squared test were used to compare qualitative data. The results were evaluated at the 95% confidence interval and at the level of significance ($p < 0.05$).

RESULTS

Thirty-five female (77.8%) and 10 male (22.2%) patients with ABP who underwent cholecystectomy were evaluated retrospectively. The patients who underwent LC after ABP treatment was completed were included in Group 1 ($n=22$), and the patients who underwent LC 2 months after ABP treatment was completed comprised Group

Table 1. General information of patients

Patients	Group 1	Group 2
Number	22	23
MRCP	5 (22.7%)	9 (39.1%)
ERCP	3 (13.6%)	7 (30.4%)
Operation time	57.8 min	45.7 min
Conversion to open cholecystectomy	3 (13.6%) patients	2 (8.7%) patients
Duration of hospitalization	13.2 days	8.3 days

MRCP: Magnetic resonance cholangiopancreatography; ERCP: Endoscopic retrograde cholangiopancreatography.

2 ($n=23$). The mean age of the patients was 56 (26–93) years. The mean duration of hospitalization was 13.18 days in Group 1 and 8.3 days in Group 2 ($p < 0.001$). USG was performed in all of the patients and gallbladder stones were detected. Enlargement of the intrahepatic bile ducts and common bile duct duct on USG and an obstructive jaundice pattern in biochemical parameters; MRCP was performed in 5 (22.7%) patients in Group 1 and 9 (39.1%) patients in Group 2. According to the MRCP result, ERCP was performed in 3 (13.6%) patients in Group 1 and 7 (30.4%) patients in Group 2. LC was performed in the first 72 hours after ERCP did not show any complication in these patients. The mean duration of LC was 57.8 min in Group 1 and 45.7 min in Group 2, with a significant intergroup difference ($p < 0.01$). Obstruction was relieved in 3 (13.6%) patients in Group 1 and 2 (8.7%) patients in Group 2. The cause of conversion to open surgery in Group 1 was excessive inflammation and inability to fully reveal the anatomical structures. In Group 2, the nature of the deficit was changed due to excessive fibrosis (Table 1). Drains were routinely placed in the operating room for all patients, and bile leakage, bleeding, and pseudocysts were not observed in any patients. No mortality was detected.

Postoperative complications were observed in a total of 8 (17.8%) patients including atelectasis in 3 patients and wound infection in 1 patient in Group 1 (total $n=4$, 18.2%) and atelectasis in 2 patients and wound infection in 2 patients in Group 2 (total $n=4$, 17.4%). There was no statis-

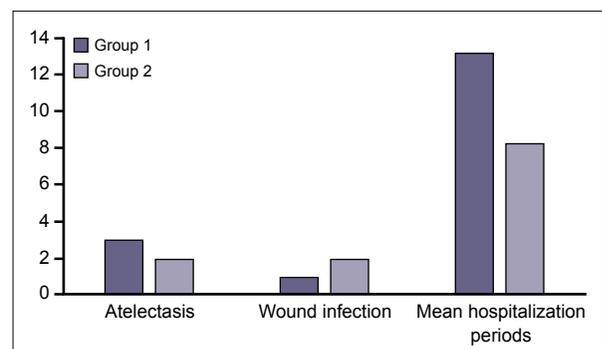


Figure 1. Postoperative complications and duration of hospitalization.

tically significant difference in postoperative complication rates between the two groups. Relapse of acute pancreatitis was observed in 1 (4.5%) patient in Group 1 who had undergone ERCP due to choledocholithiasis and in 2 (8.7%) patients in Group 2. The average length of hospital stay was 13.18 days in Group 1 and 8.3 days in Group 2 (Fig. 1).

DISCUSSION

The standard treatment for ABP is cholecystectomy. The risk of recurrent attacks of pancreatitis after cholecystectomy is 1%–2%.^[16,17] However, it has been reported that more than two-thirds of patients who did not receive treatment (LC) after the first pancreatitis attack had recurrent attacks of pancreatitis within the first 3 months.^[16,17] Attacks of recurrent pancreatitis are in the form of attacks of severe pancreatitis at a rate of 4%–50%, and the morbidity and mortality rates are 10% and 40%, respectively.^[18,19] In the past, cholecystectomy was recommended 6–8 weeks later because of the increased risk of complications and formation of inflammation due to pancreatitis. However, in treatment schemes, currently, cholecystectomy is recommended at the first hospitalization or within the first 2–4 weeks after the first attack.^[20–22] However, only 39%–51% of this patient group is treated according to these treatment schemes.^[23,24] In some studies conducted in Türkiye, it was reported that interval cholecystectomy was performed in the vast majority of patients, while cholecystectomy was performed in only 42.5%–52.1% of the patients at the first hospitalization.^[25–27]

Passage of gallstones through the common bile duct and ampulla Vater is the main cause of acute pancreatitis. Biliary decompression can be performed with ERCP and endoscopic sphincterotomy.^[20,21] In our study, the presence of biliary stones in the common bile duct was confirmed preoperatively by MRCP in 5 (22.7%) patients in Group 1 and 9 (39.1%) patients in Group 2, ERCP was performed in 3 (13.6%) patients in Group 1 and 7 (30.4%) patients in Group 2, and cholecystectomy was performed after stone removal from the common bile duct using ERCP. Other biliary events such as recurrence of biliary pancreatitis, biliary colic, cholangitis, choledochal obstruction, and acute cholecystitis may be seen in patients after ABP.^[2,23] In the literature, cholecystectomy or endoscopic sphincterotomy is recommended after ABP to prevent these recurrent biliary adverse events.^[23] LC performed at an early stage of the disease immediately after recovery from the first attack of mild or moderate biliary pancreatitis is recommended. In a large number of studies conducted by Nguyen et al.,^[23] approximately half of the patients with ABP underwent early-stage LC. Although their study population consisted of a small number of patients, the results were in agreement with our study.

In the past, there were opinions regarding the difficulty in accurately evaluating the anatomy of Calot's triangle in interventions performed immediately after an acute

pancreatitis attack, and dissection in this area was both difficult and dangerous.^[6] Bulkin et al.^[28] compared open cholecystectomy with LC when laparoscopy was first used. In our study, in all patients, LC was performed. Tang et al.^[29] also stated that dissection is difficult in early-stage LC. It has been reported that in 16%–18% of the patients, conversion to laparotomy was attempted due to dissection difficulty in LC performed for ABP. However, in recent years, it has been reported that complications and rates of conversion to laparotomy in cases of LC performed in the early stage of the disease, especially after mild biliary pancreatitis, are similar to those of patients who underwent interval cholecystectomy. In the study of Alimoglu et al.^[30] and Sinha et al.,^[31] the authors examined conversions from laparoscopic LC to open LC and could not find a statistical difference in the complication rates between early- and late-term LC. In fact, some studies have reported that adhesion and fibrosis around the gallbladder are more common in interval cholecystectomy, which complicated surgical interventions. In particular, Rosing et al.^[32] stated that the surgery is prolonged due to fibrosis in late-stage LC in ABP. In our study, a similar complication rate and rate of transition to laparotomy were observed in LC performed in the early and late stages due to ABP. Although no criteria were determined in our study on the difficulty of LC dissection, the operation time was longer in the early-term LC. The complication rate was similar in both groups, suggesting that early cholecystectomy does not pose an additional operative difficulty. Complications such as bile leakage, intra-abdominal bleeding, and pancreatic pseudocyst, which are rarely observed in different studies, were not noted in our study.

The most important point of support for the views advocating early cholecystectomy is the high rate of recurrent biliopancreatic events occurring during the waiting period in patients who will undergo interval cholecystectomy. In the literature, it has been shown that up to 18% of patients develop recurrent biliary events during the 4–8-week waiting period. In a large-scale systemic review by van Baal et al.,^[16] the authors suggested early-term LC in ABP. In our study, recurrent biliopancreatic events were observed in 8.7% (2/23) of the patients.

There are two different approaches for early cholecystectomy in ABP. The first approach is to perform cholecystectomy at the time of patient's admission. Two studies involving a limited number of patients in which this approach was evaluated reported that this approach was safe and the hospital stay was shorter in this group of patients. Rosing et al.^[32] and Aboulian et al.^[33] reported that hospital stay was shorter, especially in early-term LC. However, it has been reported that the disease progresses to severe pancreatitis in 15% of patients who were evaluated as mild to moderate ABP at their first hospitalization.^[34,35] Interventions performed without waiting for regression of clinical findings and laboratory values may cause serious morbidity and mortality. Contrary to this point of view, the other approach in ABP is to perform cholecystectomy

after clinical improvement and normalization of laboratory findings. In various studies comparing the early LC approach with interval cholecystectomy, it has been shown that early cholecystectomy is performed with similar rates of complication and conversion to open surgery.^[22,30,31] We also prefer this approach, considering that it is safer to perform cholecystectomy in ABP after clinical recovery and normalization of laboratory values.

Recurrent biliopancreatic events occurred at a higher rate in Group 2, compared to Group 1 and in which interval LC was applied. (Group 2/Group 1 = 8.7%/4.5%). The length of stay in the hospital in Group 1 was statistically significantly shorter. Similar results have been reported in other studies in the literature.^[22,30,31,36]

The retrospective nature of our study and the limited number of patients are the most important limitations of our study. Besides, patients who received only medical treatment for acute pancreatitis without surgical intervention, patients who underwent emergency palliative intervention [ERCP, laparotomy, necrosectomy (severe necrotizing pancreatitis), drainage, etc.], and patients with chronic pancreatitis and a history of alcohol use were excluded from the study.

CONCLUSION

There is still no consensus on the timing of cholecystectomy in patients hospitalized with a diagnosis of mild and moderate ABP. In the early period of ABP treatment, the duration of LC is prolonged due to adhesions, difficult dissection, and the risk of bleeding. Although operative times of early-term LC are long-lasting, no difference was found in terms of postoperative hospital stay and complications. Cholecystectomy can be performed safely after regression of ABP. We believe that early LC should be performed to protect patients from acute pancreatitis attacks that may develop later and to prevent recurrent attacks as complications of LC.

Ethics Committee Approval

This study approved by the Kartal Dr. Lütfi Kırdar City Hospital Clinical Research Ethics Committee (Date: 29.12.2021, Decision No: 2021/514/216/3).

Informed Consent

Retrospective study.

Peer-review

Internally peer-reviewed.

Authorship Contributions

Concept: A.B., E.Y.; Design: A.B., E.Y.; Supervision: A.B., M.A.; Fundings: A.B., E.Y.; Materials: A.B., E.Y.; Data: A.B., E.Y.; Analysis: A.B., E.Y., M.A.; Literature search: A.B., E.Y., M.A.; Writing: A.B., E.Y.; Critical revision: A.B., M.A.

Conflict of Interest

None declared.

REFERENCES

1. Sayek I, Turhan N. Pankreatit. In: Sayek I, editor. Temel Cerrahi. 4th ed. Ankara: Güneş Tıp Kitabevi; 2013. p. 1691–703.
2. Forsmark CE, Baillie J. AGA Institute technical review on acute pancreatitis. *Gastroenterology* 2007;132:2022–44. [[CrossRef](#)]
3. Ertekin C, Kemertaş K, Günay K, Güloğlu R. Akut pankreatit. *Ulus Travma Acil Cerrahi Derg* 1995;1:14–21.
4. Ayten R, Çetinkaya Z, Yeniçerioglu A. Akut pankreatitli olgularımızın retrospektif değerlendirilmesi. *FÜ Sağ Bil Derg* 2007;21:133–6.
5. Dixon JA, Hillam JD. Surgical treatment of biliary tract disease associated with acute pancreatitis. *Am J Surg* 1970;120:371–5.
6. Ranson JH. The timing of biliary surgery in acute pancreatitis. *Ann Surg* 1979;189:654–63. [[CrossRef](#)]
7. Frei GJ, Frei VT, Thirlby RC, McClelland RN. Biliary pancreatitis: clinical presentation and surgical management. *Am J Surg* 1986;151:170–5. [[CrossRef](#)]
8. Tate JJ, Lau WY, Li AK. Laparoscopic cholecystectomy for biliary pancreatitis. *Br J Surg* 1994;81:720–2. [[CrossRef](#)]
9. Gurusamy KS, Koti R, Fusai G, Davidson BR. Early versus delayed laparoscopic cholecystectomy for uncomplicated biliary colic. *Cochrane Database Syst Rev* 2013;6:CD007196. [[CrossRef](#)]
10. Bouwense SA, Besselink MG, van Brunschot S, Bakker OJ, van Santvoort HC, Schepers NJ, et al. Pancreatitis of biliary origin, optimal timing of cholecystectomy (PONCHO trial): study protocol for a randomized controlled trial. *Trials* 2012;13:225. [[CrossRef](#)]
11. Tenner S, Baillie J, Dewitt J, Vege SS. American College of Gastroenterology guideline: management of acute pancreatitis. *Am J Gastroenterol* 2013;108:1400–15.
12. Working Group IAP/APA Acute Pancreatitis Guidelines. IAP/APA evidence-based guidelines for the management of acute pancreatitis. *Pancreatology* 2013;13:e1–e15. [[CrossRef](#)]
13. Yokoe M, Takada T, Mayumi T, Yoshida M, Isaji S, Wada K, et al. Japanese guidelines for the management of acute pancreatitis: Japanese Guidelines 2015. *J Hepatobiliary Pancreat Sci* 2015;22:405–32.
14. Ranson JH, Rifkind KM, Roses DF, Fink SD, Eng K, Spencer FC. Prognostic signs and the role of operative management in acute pancreatitis. *Surg Gynecol Obstet* 1974;139:69–81.
15. Ranson JH. Etiological and prognostic factors in human acute pancreatitis: a review. *Am J Gastroenterol* 1982;77:633–8.
16. van Baal MC, Besselink MG, Bakker OJ, van Santvoort HC, Schaaferder AF, Nieuwenhuijs VB, et al; Dutch Pancreatitis Study Group. Timing of cholecystectomy after mild biliary pancreatitis: a systematic review. *Ann Surg* 2012;255:860–6. [[CrossRef](#)]
17. Nebiker CA, Frey DM, Hamel CT, Oertli D, Kettelhack C. Early versus delayed cholecystectomy in patients with biliary acute pancreatitis. *Surgery* 2009;145:260–4. [[CrossRef](#)]
18. Hernandez V, Pascual I, Almela P, Añon R, Herreros B, Sanchiz V, et al. 31 Recurrence of acute gallstone pancreatitis and relationship with cholecystectomy or endoscopic sphincterotomy. *Am J Gastroenterol* 2004;99:2417–23. [[CrossRef](#)]
19. Lankisch PG, Bruns A, Doobe C, Weber-Dany B, Maisonneuve P, Lowenfels AB. The second attack of acute pancreatitis is not harmless. *Pancreas* 2008;36:207–8. [[CrossRef](#)]
20. Working Party of the British Society of Gastroenterology; Association of Surgeons of Great Britain and Ireland; Pancreatic Society of Great Britain and Ireland; Association of Upper GI Surgeons of Great Britain and Ireland. UK guidelines for the management of acute pancreatitis. *Gut* 2005;54:iii1–9. [[CrossRef](#)]
21. Banks PA, Freeman ML; Practice Parameters Committee of the American College of Gastroenterology. Practice guidelines in acute pancreatitis. *Am J Gastroenterol* 2006;101:2379–400.

22. Uhl W, Warshaw A, Imrie C, Bassi C, McKay CJ, Lankisch PG, et al; International Association of Pancreatology. IAP guidelines for the surgical management of acute pancreatitis. *Pancreatology* 2002;2:565-73. [CrossRef]
23. Nguyen GC, Tuskey A, Jagannath SB. Racial disparities in cholecystectomy rates during hospitalizations for acute gallstone pancreatitis: a national survey. *Am J Gastroenterol* 2008;103:2301-7. [CrossRef]
24. Chiang DT, Thompson G. Management of acute gallstone pancreatitis: so the story continues. *ANZ J Surg* 2008;78:52-4. [CrossRef]
25. Beyazıt Ü, Taşkesen F, Büyükle A, Arıkanoğlu Z, Önder A, Kapan M, et al. Akut biliyer pankreatitli olgularda erken ve geç laparoskopik kolesistektominin yeri. *Türk J Surg* 2011;27:137-40. [CrossRef]
26. Eğin S, Yeşiltaş M, Gökçek B, Tezer H, Karahan SR. Early laparoscopic cholecystectomy following acute biliary pancreatitis expedites recovery. *Ulus Travma Acil Cerrahi Derg* 2017;23:495-500.
27. Aksoy F, Demiral G, Ekinci Ö. Can the timing of laparoscopic cholecystectomy after biliary pancreatitis change the conversion rate to open surgery? *Asian J Surg* 2018;41:307-12. [CrossRef]
28. Bulkin AJ, Tebyani N, Dorazio RA. Gallstone pancreatitis in the era of laparoscopic cholecystectomy. *Am Surg* 1997;63:900-3.
29. Tang E, Stain SC, Tang G, Froese E, Berne TV. Timing of laparoscopic surgery in gallstone pancreatitis. *Arch Surg* 1995;130:496-9; discussion 499-500. [CrossRef]
30. Alimoglu O, Ozkan OV, Sahin M, Akcakaya A, Eryılmaz R, Bas G. Timing of cholecystectomy for acute biliary pancreatitis: outcomes of cholecystectomy on first admission and after recurrent biliary pancreatitis. *World J Surg* 2003;27:256-9. [CrossRef]
31. Sinha R. Early laparoscopic cholecystectomy in acute biliary pancreatitis: the optimal choice? *HPB (Oxford)* 2008;10:332-5.
32. Rosing DK, de Virgilio C, Yaghoobian A, Putnam BA, El Masry M, Kaji A, et al. Early cholecystectomy for mild to moderate gallstone pancreatitis shortens hospital stay. *J Am Coll Surg* 2007;205:762-6.
33. Aboulian A, Chan T, Yaghoobian A, Kaji AH, Putnam B, Neville A, et al. Early cholecystectomy safely decreases hospital stay in patients with mild gallstone pancreatitis: a randomized prospective study. *Ann Surg* 2010;251:6159. [CrossRef]
34. Dambrauskas Z, Gulbinas A, Pundzius J, Barauskas G. Value of the different prognostic systems and biological markers for predicting severity and progression of acute pancreatitis. *Scand J Gastroenterol* 2010;45:959-70. [CrossRef]
35. Papachristou GI, Muddana V, Yadav D, O'Connell M, Sanders MK, Slivka A, et al. Comparison of BISAP, Ranson's, APACHE-II, and CTSI scores in predicting organ failure, complications, and mortality in acute pancreatitis. *Am J Gastroenterol* 2010;105:435-41; quiz 442. [CrossRef]
36. Dalbaşı E, Tüzün A. Early Laparoscopic Cholecystectomy After Acute Biliary Pancreatitis and ERCP Single Center Results. *Kocaeli Med J* 2020;9:160-5.

Hafif ile Orta Akut Biliyer Pankreatit Tedavisinde Erken ve Geç Dönem Laparoskopik Kolesistektomi Sonuçlarının Karşılaştırılması

Amaç: Akut pankreatit; pankreas bezinin kendi enzimlerinin aktivasyonu ile interstisyel alana serbestlenmesi ve kendi dokusunu sindirmesi sonucunda oluşan nonbakteriyel enflamasyondur. Akut pankreatitin en sık sebebi safra taşlarıdır. Akut biliyer pankreatit (ABP) tedavisinde, komplikasyonları ve nüksleri önlemek için kolesistektomi altın standarttır. Kolesistektominin zamanlaması hala tartışmalıdır. Bu çalışma da hafif ve orta derecede ABP tanısı ile kliniğimizde yatırılarak laparoskopik kolesistektomi (LK) yapılan hastaların erken ve geç dönem sonuçlarını karşılaştırmayı amaçladık.

Gereç ve Yöntem: ABP tanısı ile yatan ve LK uygulanan 45 hastanın dosyaları geriye dönük olarak incelendi. Hastalardan 35'i kadın (%77.8) ve 10'u erkek (%22.2) hastaydı. ABP tedavisi tamamlandıktan sonra LK yapılan 22 hasta Grup 1, ABP tedavisinden sonra iki aylık interval verilen ve daha sonra LK yapılan hastalar Grup 2 olarak adlandırıldı.

Bulgular: Grup 1; 22, Grup 2 ise 23 olmak üzere toplam 45 hastadan oluşmaktaydı. Olguların ortalama yaşı 56 (26-93) yıl olup, hastaların yatış süreleri; Grup 1'de ortalama 13.18, Grup 2'de 8.3 gün idi. Grup 1 hastalarında LK süresi ortalama 57.8 dakika, Grup 2'de 45.7 dakika olup anlamlı fark bulundu ($p < 0.01$). Grup 1'de 3 (%13.6), Grup 2'de iki (%8.7) hastada açığa geçildi. Ameliyat sonrası komplikasyon Grup 1'de dört (%18.1), Grup 2'de dört (%17.4) hastada görüldü. Grup 1'de bir (%4.5) hastada; Grup 2'de iki (%8.7) hastada yeniden akut pankreatit görüldü.

Sonuç: ABP tedavisinde; erken dönemde yapılan LC'nin süresi uzamış olmasına rağmen, ameliyat sonrası hastanede kalış süresi ve komplikasyonlarda fark saptanmadı. ABP ataklarından sonra gelişebilecek nüksleri ve komplikasyonları önlemek için erken LK yapılması gerektiği kanaatindeyiz.

Anahtar Sözcükler: Akut biliyer pankreatit; erken kolesistektomi; geç kolesistektomi.