Laparoscopic Cholecystectomy in the Cirrhotic: Review of Literature on Indications and Technique

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Rezumat

Colecistectomia laparoscopică în ciroză: revizuirea literaturii privind indicațiile și tehnica


Cuvinte cheie: ciroză, colecistectomie, laparoscopie
Abstract
Cholelithiasis is twice more common in patients suffering from liver cirrhosis compared to overall population and in those patients, acute cholecystitis occurs significantly more often. Our goal was to review the literature and to overview the indications, contra-indications, and alternatives in the cirrhotic with biliary stones. We conducted a systematic review of the literature using the key words “Cirrhosis”, “cholecystectomy”, “laparoscopy”, and “indications”. Selected articles were reviewed for information specific to indications, contra-indications, and alternatives to laparoscopic cholecystectomy in cirrhotics. Results showed that laparoscopic cholecystectomy might offer several advantages in cirrhotic population, however cholecystectomy can be challenging: specific indications and alternatives to surgery must be discussed case by case. Laparoscopic cholecystectomy can be performed safely in selected patients with cirrhosis: special precautions are warranted regarding pneumoperitoneum pressure, trocar placement and increased safety with Indocyanine-green (ICG) fluorescence cholangiography. Nevertheless, in high-risk cirrhotic patients (Child C) and/or in common bile duct lithiasis endoscopic and non-surgical conservative treatments are preferable.

Key words: cirrhosis, cholecystectomy, laparoscopy

Introduction
Cholelithiasis is found in about one third of patients with liver cirrhosis (1), about twice as much as in the overall population (2). Predisposing factors found in the literature include gallbladder dysmotility (reduced motility and decreased emptying) in the fibrous transformed liver, reduction in bile acidity, increased unconjugated bilirubin secretion, increased levels of estrogen, and increased intravascular hemolysis due to hypersplenism (1,3-7). Symptomatic biliary stones in patients with liver cirrhosis are associated with higher morbidity (8) and mortality rates than those in patients with a non-cirrhotic liver (9) and in particular when patients with advanced cirrhosis undergo surgery (10). Acute cholecystitis occurs more often in the cirrhotic: 47% versus 14.7% in patients with or without cirrhosis, respectively (p<0.001). Our goal was to review the literature and to overview the indications, contra-indications, and alternatives in the cirrhotic with biliary stones.

Methods
We conducted a systematic review of the literature using the key words “Cirrhosis”, “cholecystectomy”, “laparoscopy”, and “indications”. Of the 136,000 possible references, we further screened for articles in English and published in indexed journals. After eliminating redundant publications and (second hand) citations, we analyzed 32 articles (1,3,4,7-35). Selected articles were reviewed for information specific to laparoscopic cholecystectomy in cirrhotic, indications and contra-indications and possible alternatives.
copic cholecystectomy in this high-risk group of patients.

Alternatives to surgery must be discussed case by case.

**Discussion**

Liver cirrhosis increases the difficulty of cholecystectomy, particularly in those patients with severe liver fibrosis (difficulty and fragility in retraction) and portal hypertension (increased bleeding). Because of these increased risks, open cholecystectomy (OC) was originally preferred over laparoscopic cholecystectomy (LC) when surgery became necessary (4,11,12).

Several small series, randomized or not, have surfaced in the literature as early as 1993 (13), stating that laparoscopic cholecystectomy could be performed safely in selected patients with cirrhosis (9,11,14), and currently, laparoscopic cholecystectomy has become the preferred approach in specific indications (8,11,15).

However, the laparoscopic approach has specific shortcomings in the cirrhotic, and special precautions are warranted.

As the hepatic portal inflow in the cirrhotic is decreased, the hepatic buffer response is impaired (increased hepatic artery inflow to compensate the decreased portal inflow). Because of this, Cobb et al. recommend to keep the intra-abdominal pressure as low as possible, and exsufflate cautiously, intermittently (11). N’Guyen et al. made the following recommendations (36) (Table 1).

Several operative details have their importance.

1. Operative setup: while it is recognized that trocars interrupt the collateral circulation less than a midline, the periumbilical area should be avoided (37);
2. Once the first trocar is inserted, transillumination of abdominal wall allows to avoid the collaterals (37);
3. Placement of subxiphoid port to the right of the midline avoids injury to the falciform ligament and the (potentially repermeabilized) umbilical vein;
4. If the left lobe encroaches on the operative field, the surgeon should raise patient’s right shoulder and/or use a long port or converter inserted into the epigastric port, or if not sufficient, insert an extra port to retract the left lobe;
5. Intra-operatively, it is essential to avoid excessive traction on the gallbladder to avoid avulsion from the liver bed (37);
6. Last, as for other operations in the cirrhotic, especially with ascites, intra-peritoneal drains should be avoided (38).

When the patient is Child C, or MELD >13, laparoscopic surgery is not recommended and several alternatives have been suggested such as partial cholecystectomy (17) or endoscopic drainage of the gallbladder (21,28), the latter especially in patients who may someday be candidates for liver transplantation. In high risk patients with acute cholecystitis, percutaneous cholecystostomy (26,34,39) has been favored. However, in these patients, the risk of

| Table 1. |

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<th>Pre-operative</th>
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<td>a) Medically optimize the patient: control ascites, correct coagulopathy [fresh frozen plasma (when INR &gt;1.5) and platelets (&lt;50/mm$^3$)]</td>
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<td>b) Cirrhotic patients with hemoglobin &lt;10 g/dL should receive corrective blood transfusions before abdominal surgery</td>
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<td>c) Obtain pre-operative imaging to help identify abdominal wall varices or a recanalized umbilical vein and to rule-out hepatoma</td>
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<td>d) Consider cholecystostomy tube in patients with Child class C (MELD &gt; 13) (4)</td>
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<th>Intra-operative</th>
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<td>a) Use the open Hasson approach via an infra-umbilical incision to avoid periumbilical wall varices</td>
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<td>b) Transilluminate with the laparoscope to identify vascular collaterals or measure placement based on preoperative imaging</td>
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<td>c) If unsuspected cirrhosis is identified during a planned routine laparoscopic cholecystectomy, depending on the experience of the surgeon and the facilities; consider closing the fascia and skin and transferring the patient to a tertiary medical center with critical care, hepatology, and hepatobiliary and transplant surgery support</td>
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hemorrhage and/or sepsis in portal hypertension and/or ascites is high. This has led to a debate as to whether the transhepatic or transperitoneal route should be used.

The transhepatic route preferred by many because it minimizes the risk of intraperitoneal bile leak, inadvertent injury to the hepatic flexure of the colon (27) [colon positioned between skin and gallbladder fundus in 13% of patients (33)].

In order to facilitate visualization of biliary structures and to reduce time to get the critical view of safety, indocyanine green fluorescent cholangiography has been introduced in clinical practice as a promising tool. Recently, a randomized control trial (40) demonstrated that this technique is statistically significantly superior to standard technique visualizing extrahepatic biliary structures during laparoscopic cholecystectomy. However, a pre-existing liver disease was an exclusion criterion from this study. According to literature, no studies stating the feasibility of indocyanine green (ICG) fluorescent cholangiography in cirrhotic patients are available. ICG can be already used to assess portal hypertension and esophageal varices in patient with compensated liver cirrhosis (Child A) (41) and to estimate short term survival in decompensated cirrhosis thorough the ICG elimination test (42,43). One of the clinical applications of ICG (44) in fluorescence guided hepatobiliary surgery is liver mapping. Aoki et al (45) reported no significant differences in the mapping of the liver segments between non-cirrhotic and cirrhotic patients using ICG fluorescence. Taking into account these clinical applications and results, feasibility studies are necessary to determine the use of ICG fluorescence cholangiography and or near-infrared cholecystocholangiography with direct intra-gallbladder indocyanine green injection (46).

In patients with CBD stones, the risk of morbidity and mortality is high, ranging from 2 to 30-50% (16,18,23,24,30). In this setting, endoscopic management is preferred (18,19,30) although mortality is still around 15% (18,31) vs. overall complication rate of about 10% and a mortality rate of 0.5% in non-cirrhotics (20,35). Endoscopic papillary balloon dilatation without sphincterotomy is associated with a lower risk of bleeding but is of limited efficacy in case of large stones (32). Endoscopic treatment with mechanical lithotripsy or sphincterotomy is recommended for larger stones (32).

Conclusions

Laparoscopic cholecystectomy could be performed safely in selected patients with cirrhosis. Special precautions are requested regarding pneumoperitoneum pressure, trocar placement and the use of ICG fluorescence intraoperative cholangiography to increase safety during bile ducts dissection.

Nevertheless in high-risk cirrhotic patients (Child C, severe ascites) and/or in patients suffering from gallbladder and CBD stones, endoscopic and non-surgical conservative treatments are recommended.

Conflict of Interests

No conflicts of interes.

References

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