GROUPE HOSPITALIER
DIACONESSES
CROIX SAINT SIMON

Cholécystite aiguë lithiasique (CAL): Quand opérer?

Journées du GHIF – PARIS – 17 juin 2023

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Déclaration de Conflits d'intérêts

- Medtronic°: mission d'enseignement
- Intuitive Surgical°: contrat de proctoring

- **CAL: état des lieux**
- **CAL: définition, diagnostic**
- **Cholécystectomie: abord, morbidité**
- **Alternatives à la cholécystectomie**
- **Quand opérer? Les indications**
- **Quand opérer? Le délai**

CAL: état des lieux

Pathologie fréquente

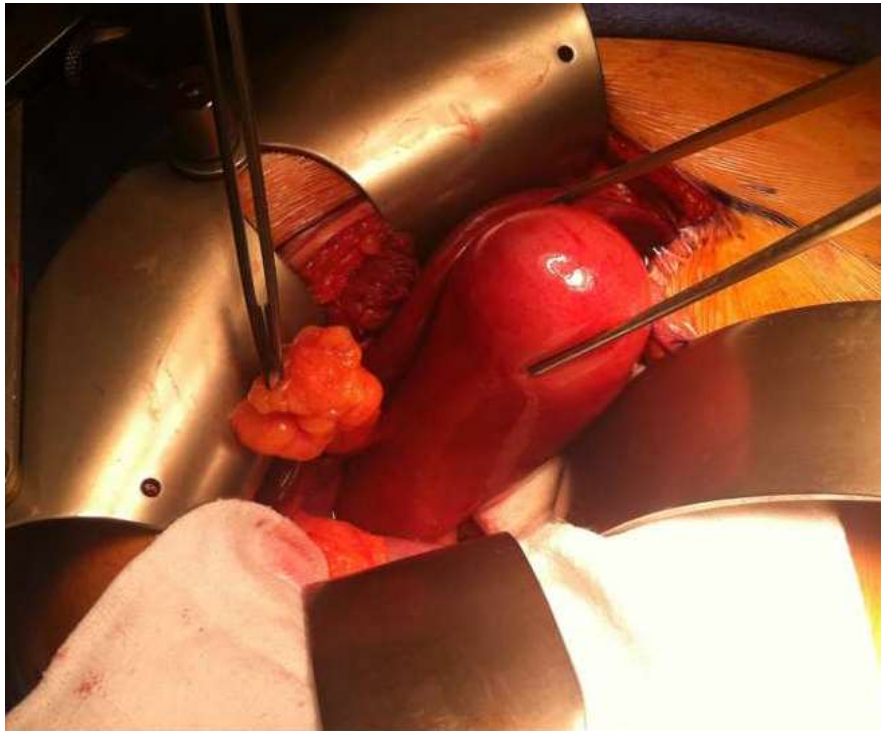
- 3ème cause d'admission en urgence en chirurgie
- en 2010 en France, 37500 cholécystectomies pour CAL
- augmentation de l'incidence de 5% par rapport à 2007
- Enjeux médicaux et socio-économiques

www.has-sante.fr/portail/upload/docs/application/pdf/2013-03/points-cle_solution_-_problematique_cholecystectomie.pdf

CAL: définition et diagnostic

Définition

- inflammation de la paroi vésiculaire: oédème, hyperhémie, péritonite purulente, gangrène, empyème
- Contenu vésiculaire:
  - Infecté: secondairement (60% JAMA. 2014; 312:145-54.), pyocholécystite
  - Hémorragique



CAL: définition et diagnostic

Diagnostic (clinique + bio + echographie)

- Douleur biliaire: mais… HCD, épaule droite, fièvre
- Irritation péritonéale: murphy, défense
- Biologie inflammatoire, parfois cytolyse (pédiculite)

Echographie abdominale

- Diag + > 90%
- paroi > 4mm, épanchement péri, calculs

Diagnostic criteria and severity assessment of acute cholecystitis: Tokyo Guidelines. J Hepatobiliary Pancreat

CAL: définition et diagnostic

Echographie abdominale

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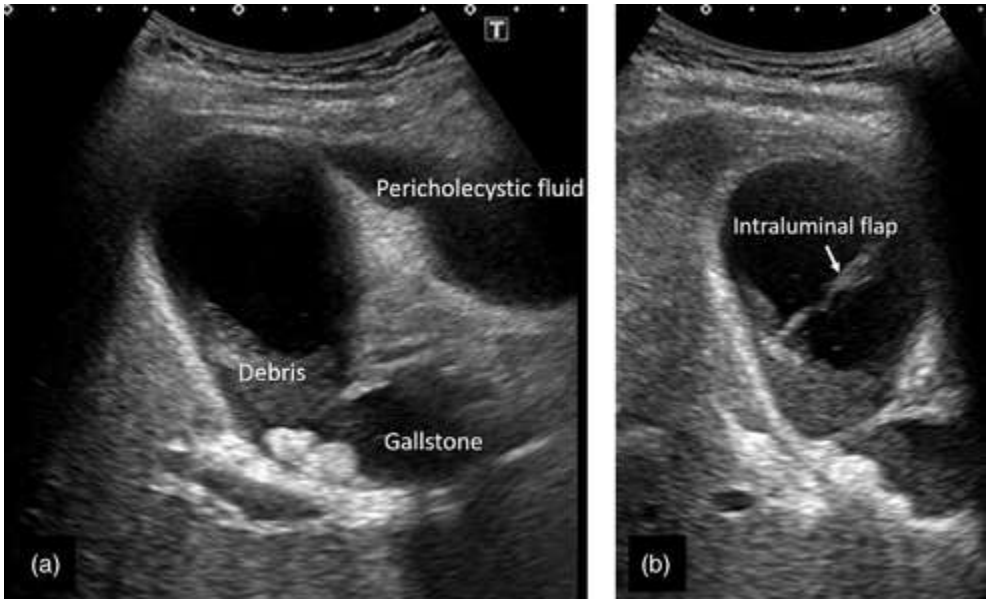
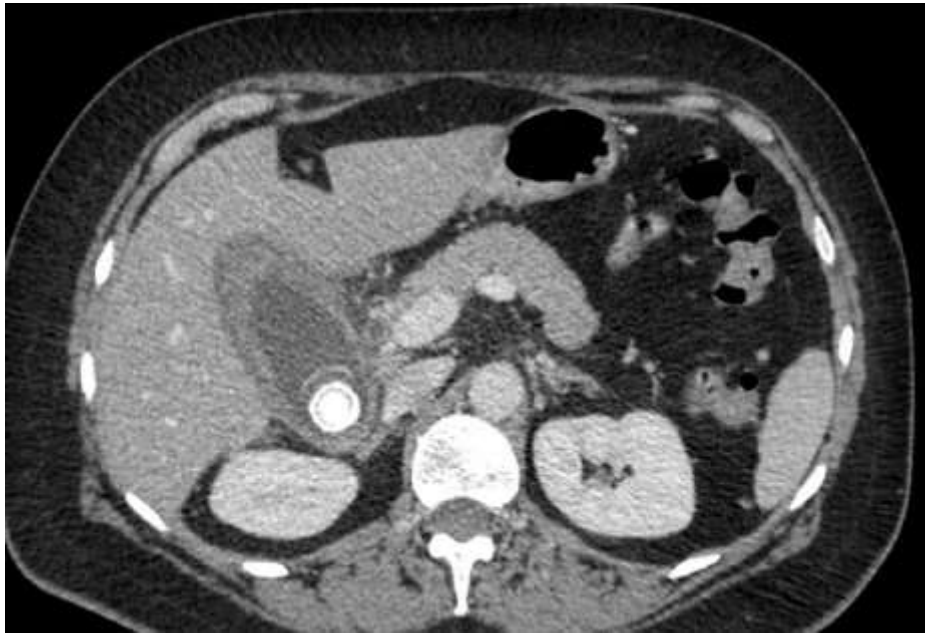


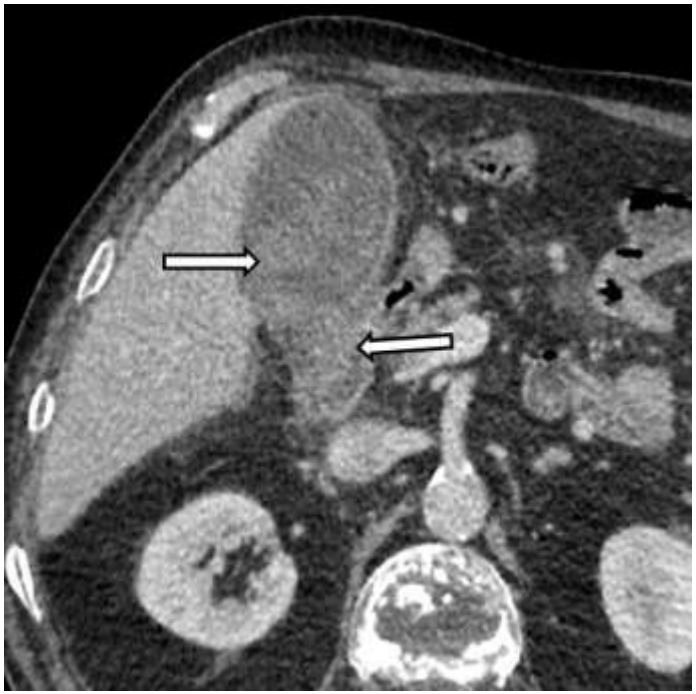
Diagnostic criteria and severity assessment of acute cholecystitis: Tokyo Guidelines. J Hepatobiliary Pancreat

CAL: définition et diagnostic

TDM abdominale injectée

- Si atypique, formes compliquées (hémorragique)





AJR Am J Roentgenol. 1996; 166: 1085-8.

La cholécystectomie

Coelioscopie ou Laparotomie?

- A froid: Coelio = Traitement de référence Cochrane Database Syst Rev. 2006; 18:CD006231
- CAL:
  - Morbi-mortalité: coelio = laparo
  - Durée de séjour: coelio>laparo

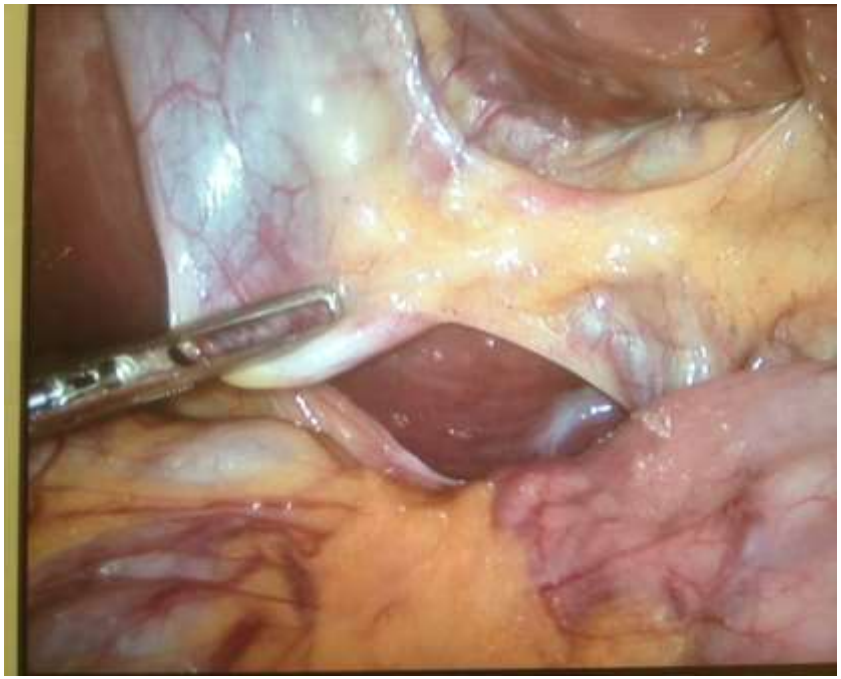
  Br J Surg 2005; 92:44-49 et Lancet 1998; 31:321-325
- Plaie des voies biliaires:

  - 0,5 à 0,82%, taux de détection per-op faible (40 à 80%)

  Gossage IntJClinPract 2010, Ludwig Surg Endosc 2002

  - Coelio (0,82%) > Lap (1,24%) n=8349

  Surg Endosc. 2011; 25:2906-10



Vue opératoire à froid

Vue opératoire: cholécystite rétractile

La cholécystectomie

Table 2. Relationship between severity and 30-day overall mortality

Severity grading				
	Grade I	**Grade II**	**Grade III**	***P*-value**
	***n* = 1,339**	***n* = 1,702**	***n* = 680**	
30-day mortality	15 (1.1%)	13 (0.8%)	37 (5.4%)	<0.001

Diagnostic criteria and severity assessment of acute cholecystitis: Tokyo Guidelines. J Hepatobiliary Pancreat

Quand opérer? Les indications

Critères du Tokyo Guideliness Tokyo Guidelines. J Hepatobiliary Pancreat Surg. 2007; 14:78-82

Grade I (mild) acute cholecystitis

"Grade I" acute cholecystitis does not meet the criteria of "Grade III" or "Grade II" acute cholecystitis. It can also be defined as acute cholecystitis in a healthy patient with no organ dysfunction and mild inflammatory changes in the gallbladder, making cholecystectomy a safe and low-risk operative procedure

Grade II (moderate) acute cholecystitis

"Grade II" acute cholecystitis is associated with any one of the following conditions:

1. Elevated WBC count (>18,000/mm^3)
2. Palpable tender mass in the right upper abdominal quadrant
3. Duration of complaints >72 h[a]
4. Marked local inflammation (gangrenous cholecystitis, pericholecystic abscess, hepatic abscess, biliary peritonitis, emphysematous cholecystitis)

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Grade III (severe) acute cholecystitis

"Grade III" acute cholecystitis is associated with dysfunction of any one of the following organs/systems:

1. Cardiovascular dysfunction: hypotension requiring treatment with dopamine ≥5 μg/kg per min, or any dose of norepinephrine
2. Neurological dysfunction: decreased level of consciousness
3. Respiratory dysfunction: PaO_2/FiO_2 ratio <300
4. Renal dysfunction: oliguria, creatinine >2.0 mg/dl
5. Hepatic dysfunction: PT-INR >1.5
6. Hematological dysfunction: platelet count <100,000/mm^3

Quand opérer? Les indications

Grades 1 et 2: CHIRURGIE

Grades 3:

- Tt CONSERVATEUR + drainage vésiculaire
- Si echec: CHIRURGIE (mortalité jusqu'à 21,4%)

Tokyo Guidelines. J Hepatobiliary Pancreat Surg. 2007; 14:78-82
J Gastroenterol Hepatol. 2009; 24:1857-61

Quand opérer? le délai (1)

Randomized Controlled Trial > Surg Endosc. 2004 Sep;18(9):1323-7.
doi: 10.1007/s00464-003-9230-6. Epub 2004 Jul 7.

Early versus delayed laparoscopic cholecystectomy for acute cholecystitis: a prospective randomized trial

	Early	Delayed
Conversion	25%	25%
Durée op	104mn	93mn
Morbidité	15%	20%
Durée séjour	4,1	10,1

Review > Cochrane Database Syst Rev. 2006 Oct 18;(4):CD005440.
doi: 10.1002/14651858.CD005440.pub2.

Early versus delayed laparoscopic cholecystectomy for acute cholecystitis

Summary of findings for the main comparison. Early versus delayed laparoscopic cholecystectomy for acute cholecystitis

Early versus delayed laparoscopic cholecystectomy for people with acute cholecystitis

Patient or population: people with acute cholecystitis.
Settings: secondary or tertiary care.
Intervention: early versus delayed laparoscopic cholecystectomy.

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Quality of the evidence (GRADE)
	Assumed risk	Corresponding risk			
	Control	Early versus delayed laparoscopic cholecystectomy			
Mortality	**0 per 1000**	**0 per 1000**	not estimable (there were no deaths in either group)	438 (5 studies)	⊖⊖⊖⊖ **very low** [1,2]
Bile duct injury	**9 per 1000**	**4 per 1000** (0 to 42)	**Peto OR 0.49** (0.05 to 4.72)	438 (5 studies)	⊖⊖⊖⊖ **very low** [1,2,3]
Other serious complications	**50 per 1000**	**65 per 1000** (31 to 137)	**RR 1.29** (0.61 to 2.72)	438 (5 studies)	⊖⊖⊖⊖ **very low** [1,2,3]
Conversion to open cholecystectomy	**221 per 1000**	**197 per 1000** (139 to 277)	**RR 0.89** (0.63 to 1.25)	488 (6 studies)	⊖⊖⊖⊖ **very low** [1,2,3]
Hospital stay	The mean hospital stay in the control groups was **8.7 days**	The mean hospital stay in the intervention groups was **4.12 lower** (5.22 to 3.03 lower)		373 (4 studies)	⊖⊖⊖⊖ **moderate** [1]
Operating time	The mean operating time in the control groups was **99.1 minutes**	The mean operating time in the intervention groups was **1.22 lower** (3.07 lower to 0.64 higher)		488 (6 studies)	⊖⊖⊖⊖ **moderate** [1]
Return to work	The mean return to work in the control groups was **26 days**	The mean return to work (to be removed before submission) in the intervention groups was **11 lower**		36 (1 study)	⊖⊖⊖⊖ **very low** [4,5,6]

Conclusion

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- Les critères du Tokyo Guidelineness apprécient la sévérité d'une cholécystite aiguë lithiasique

- Grades 1 et 2 (légère à modérée) = Cholécystectomie
- Grade 3 (sévère, défaillance d'organe) = Tt conservateur avec drainage, chirurgie si échec

- Dans quel délai? Précocément (5 premiers jours d'évolution)