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Urgent Laparoscopic Surgery on a Previously Operated Abdomen

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There are two different modifications of creation of pneumoperitoneum and inserting of video port into the previously operated abdomen:
Open method: trocar insertion with Hasson's rule, which means minilaparotomy with eye and finger control, and insertion of first trocar in abdominal cavity and creation of pneumoperitoreum with trocar Closed method: elevation of abdominal wall with towel clips, establishment of pneumoperitoneum with the Veress needle and under ultrasound control insertion of the first trocar in the safe area (as the studies show such approach has 95,5% of sensibility)
At present development of mini invasive, namely the laparoscopic technologies in the hands of an experienced surgeon almost all cases gives possibility to perform intervention on a previously operated abdomen (100% in accordance with the data of our clinic). This is very important for the patients, because their hospital stay will be short and rehabilitation process will be fast. All the above mentioned is also extremely significant with the financial point of view as the short hospitalization period will reduce state expenses for each patient.

Key Words: Previously operated abdomen, laparoscopic surgery, safe pneumoperitoreum, methods of creation pneumoperitoreum, adhesiolisis.

Intraduction: The previously operated abdomen at the early stage of mini invasive surgery was estimated as an absolute contraindication of laparoscopic intervention. Recently, perfection of laparoscopic technologies, gathering of surgical experience and aptness of operational techniques made possible the surgical intervention on a previously operated abdomen with laparoscopic approach. All the mentioned caused decreased of patients' stay at hospitals and brought to short period of rehabilitation and regeneration of employability in very short period of time. Moreover, it reduced expenses of treatment.
As it is known creation of pneumoperitoneum and the first insertion of trocars represents one of the most important stage of laparoscopic intervention – especially in case of a previously operated abdomen because the postoperative adhesions increases possibility of gastrointestinal tract injury.

Materials and Methods: There are two different modifications of creation of pneumoperitoneum and inserting of video port into the previously operated abdomen:
1) Open method: trocar insertion with Hasson's rule, which means minilaparotomy with eye and finger control, and insertion of first trocar in abdominal cavity and creation of pneumoperitoreum with trocar

2) Closed method: elevation of abdominal wall with towel clips, establishment of pneumoperitoneum with the Veress needle and under ultrasound control insertion of the first trocar in the safe area (as the studies show such approach has 95,5% of sensibility).

Surgical technique: After inserting the first trocar we place the second one with visual control to expose area and remove the adhesion with sharp instrument.
While intervention with the laparoscopic approach on the previously operated ambomen there arises quastions: is it necessary to remove the abdomen symtomless adhesion ? and if it is, what in the scale? The core point here is the aim and the task that arises with each and concrete laparoscopic intervention. Considering the early postoperative small-bowel obstruction pathogenesis and for the minimization expected complications there is not shown the laparoscopic adhesiolysis in case of symtomless viscero-visceral and viscero-parietal adhesion if they do not prevent diagnostic laparoscopy or laparoscopic interventions.

Our experience: In total 325 planed and urgent laparoscopic interventions was performed at the Tbilisi Central Hospital in 2012-2013 years. From this figure 16% was laparoscopic interventions of the previously operated abdomen . The 65.4% all of the laparoscopic interventions on a previously operated abdomen were urgent. The 58.8% of patients were female and the 41.2% of patient were male. The 26.5% of the patients had two or more laparotomic intervention on the upper part of abdomen for Diffuse Peritonitis, Gunshot Injuries, Perforated Ulcer, Cholecystectomy, Adrenalectomy and Spreading Abdominal Aneurysm. The 64.7% patients had laparotomy on the lower part of abdomen because of Appendectomy, Uterine Extirpation, Ovary Resection, Tubectomy, Ovarectomy. The 8.8% of the patients were operated for Cholecystectomy, Appendectomy, Tubectomy with laparoscopic approach The open method were used for the 64.7% of patients, and the closed method for the 35.3% of patients. The Diagnostic laparoscopy were made for 41.2% of patients, The Laparoscopic cholecystectomy for 47% of patient and the Laparoscopic appendectomy were made for 11.8% of patients. All the interventions were done without complications. In all cases, length of hospital stay was one day.

Conclusion: At present development of mini invasive, namely the laparoscopic technologies in the hands of an experienced surgeon almost all cases gives possibility to perform intervention on a previously operated abdomen (100% in accordance with the data of our clinic). This is very important for the patients, because their hospital stay will be short and rehabilitation process will be fast.
All the above mentioned is also extremely significant with the financial point of view as the short hospitalization period will reduce state expenses for each patient.

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ნაოპერაციები მუცლის გადაუდებელი ლაპარასკოპიული ქირურგია (ცენტრალური ჰოსპიტალი,თბილისი,საქართველო)

ნაოპერაციები მუცელი, მინიინვაზიური ქირურგიის განვითარების ადრეულ ეტაპზე, ლაპაროსკოპიული ჩარევის აბსოლუტურ უკუჩვენებად ითვლებოდა. დღეისათვის, ლაპაროსკოპიული ტექნოლოგიები განვითარება თითქმის ყველა შემთხვევაში იძლევა საშუალება ამ მიდგომით შესრულდეს ქირურგიული ჩარევა ნაოპერაციებ მუცელზე.
თბილისის ცენტრალურ საავადმყოფოში 2012-2013 წლებში გაკეთდა 325 ურგენტული და გეგმიური ოპერაცია ლაპაროსკოპიული მიდგომით. აქედან 16% იყო ნაოპერაციები მუცლის ლაპაროსკოპიული ოპერაცია, რომლის 65.4% იყო გადაუდებელი. პაციენტების 58.8% იყო ქალი და 41.2% მამაკაცი. ამ პაციენტების 26.5% ორი და მეტი ლაპაროტომიული ჩარევა ჰქონდა გადატანილი სხვადასხვა მიზეზების გამო ვიყენებდით პნევმოპერიტონეუმის შექმნისა და ვიდეოპორტის მუცლის ღრუში შეყვანის ორ ძირითად მეთოდს: ღია – ტროაკარის ჩადგმის ჰასონის წესს – 64.7%. და დახურულს – ვერეშის ნემსს ულტრაბგერის კონტროლით, – 35.3% . პირველი პორტის ჩადგმის შემდეგ, ვიზუალური კონტროლით, შეხორცებებისგან თავისუფალ ადგილას შეგვყავდა მეორე ტროაკარი და შემდგომ მჭრელი ინსტრუმენტით ვახდენდით შეხორცებებისგან სხვა ტროაკარების შესაყვანი ადგილებისა და საოპერაციო არის განთავისუფლებას. ამ მეთოდების გამოყენებამ, ჩვენს მიერ ჩატარებულ ყველა შემთხვევაში მოგვცა ლაპაროსკოპიული მიდგომით ოპერაციების წარმოების საშუალება. ყოველივე ეს, მნიშვნელოვანია პაციენტის ადრეული რეაბილიტაციისათვის. ამასთან ხანმოკლე ჰოსპიტალიზაციის პერიოდი ბევრად ამცირებს თითოეული პაციენტის მკურნალობის ხარჯებს.