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**Literature search results**

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**Search details**

Patient upon whom a laparoscopic cholecystectomy was performed. The patient had postoperative biliary peritonitis due to having a cholecystohepatic duct.

What is the current evidence and incidence of this complication? How do patients present with cholecystohepatic ducts/ducts of luschka/accessory hepatic ducts?

**Resources searched**

NHS Evidence; TRIP Database; Cochrane Library; EMBASE; MEDLINE; Google Scholar; Google Advanced Search

**Database search terms**

exp CHOLECYSTECTOMY, ("laparoscopic cholecystectomy"
OR cholecystectomy), ("gallbladder remov*" OR "removal of gallbladder" OR "gallbladder fossa" OR "gallbladder fossa remov*" OR "removal of gallbladder fossa"), exp GALLBLADDER/, gallbladder, "open cholecystectomy", exp BILIARY PERITONITIS, exp PERITONITIS, (peritonitis OR "biliary peritonitis" OR "bile duct* leak*" OR "bile peritonitis"
OR "bile leak*" OR "bile duct* injur*")], ("cholecystohepatic duct*" OR "duct* of luschka" OR "cholecystohepatic duct* of luschka" OR "bile duct* of luschka" OR "supravesical duct*"
OR "subvesical duct*" OR "hepatic duct*" OR "accessory hepatic duct*" OR AHD), exp BILE LEAKAGE, exp POSTOPERATIVE COMPLICATION, ("postoperative complication*"
OR "post operative complication*" OR "post-operative complication*"), ("post-laparoscopic cholecystectomy* complication*" OR "postlaparoscopic cholecystectomy* complication*" OR "post laparoscopic cholecystectomy* complication* OR "postoperative cholecystectomy* complication*" OR "postoperative cholecystectomy* complication*"
OR "postoperative cholecystectomy* complication*" OR "postcholecystectomy* complication*"
OR "postcholecystectomy* complication*" OR "post cholecystectomy* complication*"
OR "cholecystectomy* complication*" OR "post-cholecystectomy* complication* OR "cholecystectomy* complication*"
OR "postcholecystectomy* bile leak*" OR "post cholecystectomy* bile leak*"
OR "post-cholecystectomy* bile leak*"

**Summary**

**Incidence:**
2.6% of 1835 laparoscopic cholecystectomy (LC) operations showed bile duct anomalies (3), 2 cases of duct of Luschka out of 1351 LC operations (26), 1 case of duct of Luschka out of 185 LC operations (32), 5 bile leaks all found to be from accessory hepatic ducts out of 250 LC operations (37), 4 cases of duct of Luschka out of 64 operations (28), 15 bile leaks were caused by duct of Luschka out of 80 bile leak cases post-cholecystectomy (16) and 26 (13%) bile leaks were caused by duct of Luschka out of 207 bile leaks cases post-cholecystectomy (19).

**Prevention and detection:**
Careful clinical examination should always be ensured (26). Pre-operative placement of endoscopic nasobiliary drainage tube (ENBD) decreases complications (3). Endoscopic retrograde cholangiopancreatography (ERCP) is the most common diagnostic tool (9, 10, 19, 37) but others methods are available (9).

**Treatment:**
Methods of treatment include: endoscopic sphincterotomy (1, 9, 10, 28, 32, 37), plastic stent placement (1, 9, 10, 28), nasobiliary drain placement (1, 28, 32), further laparoscopy in a minority of cases (1, 26), ligation of the injured ducts (1).

**Guidelines**
None found.

**Evidence-based reviews**
None found.

**Published research**

1. **Temporary placement of a newly designed, fully covered, self-expandable metal stent for refractory bile leaks**

   **Author(s):** Hwang J.C., Yoo B.M., Lim S.-G., Kim J.H., Kim W.H., Kim M.W.
   **Citation:** Gut and Liver, March 2011, vol./is. 5/1(96-99), 1976-2283 (March 2011)
   **Publication Date:** March 2011
   **Abstract:** Bile leaks remain a significant cause of morbidity for patients undergoing laparoscopic cholecystectomy. Leakage from an injured duct of Luschka (subvesical duct) follows the cystic duct as the most common cause of postcholecystectomy bile leaks. Although endoscopic sphincterotomy, plastic-stent placement, or nasobiliary-drain placement are effective in healing biliary leaks, in patients in whom leakage persists and the symptoms worsen despite conventional endoscopic treatment, re-exploration with laparoscopy and ligation of the injured subvesical duct should be considered. We present herein the case of a 31-year-old woman with refractory bile leakage from a disrupted subvesical duct after cholecystectomy that could not be managed with endoscopic sphincterotomy and plastic-stent placement. A newly designed, fully covered, self-expandable metal stent (FC-SEMS) was successfully placed for the treatment of refractory bile leaks in this patient. It appears that temporary placement of an FC-SEMS is technically feasible and provides an effective alternative to surgical therapy for refractory bile leaks after cholecystectomy.
   **Source:** EMBASE

2. **ENBD tube placement prior to laparoscopic cholecystectomy may reduce the rate of complications in cases with predictably complicating biliary anomalies**

   **Author(s):** Noji T., Nakamura F., Nakamura T., Kato K., Suzuki O., Ambo Y., Kishida A., Maguchi H., Kondo S., Kashimura N.
   **Citation:** Journal of Gastroenterology, January 2011, vol./is. 46/1(73-77), 0944-1174;1435-5922 (January 2011)
Publication Date: January 2011

Abstract: Background: The risk factors predisposing to bile duct injury or postoperative bile leakage associated with laparoscopic cholecystectomy (LC) include the presence of an accessory hepatic duct, the anomalous cystic duct confluence, and duct of Luschka. One method to prevent bile duct injury is preoperative placement of an endoscopic nasobiliary drainage tube (ENBD assisted LC). The aims of this investigation are first, to report the incidence of bile duct anomalies according to the classification system proposed by Wakayama Medical University and second, to evaluate the efficacy of ENBD assisted LC with regard to prevention of intraoperative bile duct injury and postoperative bile duct injury or leakage. Methods: A total of 1,835 consecutive LCs performed at our institution during a recent 10-year period were reviewed. Results: Anomalous cystic duct confluence was detected in 11 cases and an accessory hepatic duct was detected in 37 cases. These anomalies were risk factors for bile duct injury in our series. However, there was no significant difference in the length of surgery, conversion rate to laparotomy, or frequency of bile duct injury or leakage between the standard LC group and ENBD assisted LC group. Conclusion: A bile duct anomaly was seen in 2.6% of LC cases. Placement of an ENBD tube prior to LC in predictably complicating bile duct anomalies may have successfully decreased the incidence of complications.

Source: EMBASE

4. Incidence, pattern and management of bile duct injuries during cholecystectomy: Experience from a single center


Citation: Digestive Surgery, November 2010, vol./is. 27/5(375-379), 0253-4886 (November 2010)

Publication Date: November 2010

Abstract: Background: The incidence and pattern of bile duct injury (BDI) may be underreported because of the heterogeneous referral from multiple institutions. Methods: Retrospective analysis of data from 5,782 cholecystectomies performed between 1989 and 2007 was done. BDI were categorized into Strasberg types. Results: Fifty-seven (1%) patients sustained BDI. Ten of 57 (18%) patients had minor BDI (type A-10), 25/57 (44%) had major BDI (type C-3, type D-14, type E-8) and BDI could not be classified in the remaining 22/57 (39%) patients. Twenty-one of 25 (84%) major BDI were detected at operation - 21/57 (37%) injuries were detected and repaired intra-operatively. The other 36/57 (63%) injuries were detected after operation - 11 were managed expectantly, 5 had endoscopic stenting, 3 underwent percutaneous drainage of bilioma, 1 had a laparoscopic clipping of the subvesical duct, 4 underwent laparotomy and 12 required a combination of interventions. Five of the 57 (9%) patients died. At follow-up, 1 patient developed bile duct stenosis which was managed endoscopically. All other patients were doing well at the last follow-up. Conclusions: In experienced centers, most of the major BDI can be detected and managed during cholecystectomy. Good results can be achieved by judicious selection of a combination of interventions in the majority of patients. Copyright 2010 S. Karger AG, Basel.

Source: EMBASE

10. Bile leak from the duct of Luschka

Author(s): Neumann H., Fry L.C., Malfertheiner P., Monkmuller K.

Citation: Zeitschrift fur Gastroenterologie, February 2010, vol./is. 48/2(256-257), 0044-2771 (February 2010)

Publication Date: February 2010

Abstract: A 64-year-old diabetic man underwent an open cholecystectomy for acute necrotizing cholecystitis. Post-operatively he developed a biloma which was drained percutaneously. A bile leak was suspected and he underwent an ERCP. Initial cholangiography was normal, but upon continued injection of contrast agent, a bile leak originating from a branch of the right hepatic duct or duct of Luschka became evident. A sphincterotomy was performed and a plastic stent was placed into the common bile duct.
The leak resolved and the plastic stent was removed 6 weeks later. Georg Thieme Verlag KG Stuttgart.

**Source:** EMBASE

### 11. Anatomical variations and congenital anomalies of extra hepatic biliary system encountered during laparoscopic cholecystectomy

**Author(s):** Talpur K.A.H., Laghari A.A., Yousfani S.A., Malik A.M., Memon A.I., Khan S.A.

**Citation:** Journal of the Pakistan Medical Association, February 2010, vol./is. 60/2(89-93), 0030-9982 (February 2010)

**Publication Date:** February 2010

**Abstract:** Objective: To assess the frequency of anatomical variations of extrahepatic biliary system in patients undergoing laparoscopic cholecystectomy. Methods: This is an observational study performed in the Department of Surgery, Liaquat University of Medical and Health Sciences, Jamshoro for a period of four years from January 2004 to December 2007. All diagnosed patients of cholelithiasis undergoing routine laparoscopic cholecystectomy were assessed for anatomical/congenital extra hepatic biliary and vascular anomalies. Structures mainly assessed for anomalies were gall bladder, cystic duct, supraduodenal part of Common Bile Duct (CBD), cystic artery and hepatic artery which are routinely handled during laparoscopy. However, assessment of variations and anomalies, of hepatic ducts, portal vein, retroduodenal and pancreatic parts of CBD were not done due to possibility of iatrogenic injuries. Results: Three hundred cases of cholelithiasis comprising 255 (85%) females and 45 (15%) males with mean age of 39.85 +/- 18.82 years were included in the study. Patients mainly presented with upper abdominal pain including pain in right hypochoondrium (71.67%), pain in right hypochondrium and epigastrium (19%) and pain in epigastrium alone (9.33%) as main symptoms. Operative findings revealed variations in 61 (20.33%) patients mainly involving cystic artery (10.67%), cystic duct (4.33%), right hepatic artery (2.67%) and gallbladder (2%). Postoperatively 3.67% revealed bleeding and 1.67% biliary leak from drain as main complications related to anatomical variations giving rise to 1% morbidity, however, no mortality was seen in this series. Conclusion: Congenital anomalies and normal variants of biliary tree, are not common but may be of significance during laparoscopic surgery as failure to recognize them leads to iatrogenic injuries and can increase morbidity and mortality.

**Source:** EMBASE


**Author(s):** Spanos CP, Syrakos T

**Citation:** Langenbecks Archives of Surgery, September 2006, vol./is. 391/5(441-7), 1435-2443;1435-2443 (2006 Sep)

**Publication Date:** September 2006

**Abstract:** BACKGROUND: Gallstone disease remains the most common disease of the digestive system in Western societies and laparoscopic cholecystectomy one of the most common surgical procedures performed. Bile leaks remain a significant cause of morbidity for patients undergoing this procedure. These occur in 0.2-2% of cases. The bile ducts of Luschka, or subvesical ducts, are small ducts which originate from the right hepatic lobe, course along the gallbladder fossa, and usually drain in the extrahepatic bile ducts. Injuries to these ducts are the second most frequent cause of postcholecystectomy bile leaks.METHODS: A literature search using MEDLINE's Medical Subject Heading terms was used to identify recent articles. Cross-references from these articles were also used.RESULTS: Subvesical bile duct leaks can be detected by drip-infusion cholangiography using computed tomography preoperatively, direct visualization or cholangiography intraoperatively, and fistulography, endoscopic retrograde cholangiopancreatography (ERCP), and magnetic resonance cholangiopancreatography with intravenous contrast postoperatively. ERCP is the most common diagnostic method used. Most patients with subvesical duct leaks are symptomatic, and most leaks will be detected postoperatively during the first postoperative week. Drainage of extravasated bile is mandatory in all cases. Reduction of intrabiliary pressure with endoscopic sphincterotomy and stent placement will lead to preferential flow of bile through the papilla,
thus permitting subvesical duct injuries to heal. This is the most common treatment modality used. In a minority of patients, relaparoscopy is performed. In such cases, the leaking subvesical duct is visualized directly, and ligation usually is sufficient treatment. Simple drainage is adequate treatment for a small number of asymptomatic patients with low-volume leaks.

**CONCLUSIONS:** Subvesical duct leaks occur after cholecystectomy regardless of gallbladder pathology or urgency of operation. They have been encountered more frequently in the era of laparoscopic cholecystectomy. Intraoperative cholangiography does not detect all such leaks. Staying close to the gallbladder wall during its removal from the fossa is the only known prophylactic measure. ERCP and stent placement are the most common effective diagnostic and therapeutic methods used. Intraoperative and perioperative adjunctive measures, such as fibrin glue instillation and pharmacologic relaxation of the sphincter of Oddi, can potentially be used in lowering the incidence of subvesical bile leaks.

**Source:** MEDLINE

**Full Text:** Available in [fulltext](#) at EBSCO Host

### 16. Impact of endoscopic intervention in 100 patients with suspected postcholecystectomy bile leak.

**Author(s):** Kaffes AJ, Hourigan L, De Luca N, Byth K, Williams SJ, Bourke MJ

**Citation:** Gastrointestinal Endoscopy, February 2005, vol./is. 61/2(269-75), 0016-5107;0016-5107 (2005 Feb)

**Publication Date:** February 2005

**Abstract:** BACKGROUND: Bile leak is a recognized complication of cholecystectomy. Endoscopic intervention is widely accepted as a treatment for this complication, but the optimal form is not well defined. METHODS: An ERCP database was reviewed retrospectively to identify all cases of bile leak related to cholecystectomy. Patient records and endoscopy reports were reviewed, and structured telephone interviews were conducted to collect data. RESULTS: A total of 100 patients (61 women, 39 men; mean age, 53 [17] years) with suspected postcholecystectomy bile leak were referred for ERCP. Cholecystectomy was commenced laparoscopically in 83 patients (with an open conversion rate of 30%). The most common symptoms were pain (n = 62) and fever (n = 37). Cholangiography was obtained in 96 patients. A leak was identified in 96/96 patients, the most common site being the cystic-duct stump (48), followed by ducts of Luschka (15), the T-tube site (7), and other sites (10). Treatment included stent insertion alone (40), sphincterotomy alone (18), combination stent/sphincterotomy (31), none (6), and other (1). Three patients with major bile-duct injuries were excluded from the analysis. Endoscopic therapy was unsuccessful in 7 patients (6 in the sphincterotomy alone group; p = 0.001). Four patients underwent surgery subsequent to ERCP to control the leak. All 4 were in the sphincterotomy alone group (p = 0.001). Post-ERCP pancreatitis developed in 4 patients (3 mild, 1 moderate). CONCLUSIONS: The optimal endoscopic intervention for postcholecystectomy bile leak should include temporary insertion of a biliary stent.

**Source:** MEDLINE

**Full Text:** Available in [fulltext](#) at the ULHT Library and Knowledge Services' eJournal collection

### 26. Postlaparoscopic cholecystectomy bile leak secondary to an accessory duct of Luschka

**Author(s):** Ramia J.M., Muffak K., Mansilla A., Villar J., Garrote D., Ferron J.A.

**Citation:** JSLS : Journal of the Society of Laparoendoscopic Surgeons / Society of Laparoendoscopic Surgeons, April 2005, vol./is. 9/2(216-217), 1086-8089 (2005 Apr-Jun)

**Publication Date:** April 2005

**Abstract:** Complications produced by the sectioning of a nonvisualized duct of Luschka are uncommon during laparoscopic cholecystectomy. From 1999 through 2003, we performed 1351 laparoscopic cholecystectomies in our department and observed 2 cases (0.15%) of bile leakage due to duct of Luschka injury. Injury during laparoscopic cholecystectomy is usually produced by an excessively deep plane of dissection and by the anatomical localization of this accessory duct. Clinical symptoms are scarce after duct of Luschka
injury. Numerous diagnostic methods have been used to detect these injuries. Nevertheless, careful clinical examination is still of the utmost importance. Noninvasive treatments are usually effective. In patients who present with acute abdomen, as in our cases, or who are not cured by noninvasive treatments, exploratory laparotomy is the best approach. The surgical treatment consists of a lavage of the abdominal cavity, closure of the duct of Luschka, and intraoperative cholangiography to confirm that the biliary tree is intact.

Source: EMBASE

Full Text: Available in fulltext at National Library of Medicine


Author(s): Sandha GS, Bourke MJ, Haber GB, Kortan PP

Citation: Gastrointestinal Endoscopy, October 2004, vol./is. 60/4(567-74), 0016-5107:0016-5107 (2004 Oct)

Publication Date: October 2004

Abstract: BACKGROUND: Bile leak is among the most common complications of cholecystectomy. Endoscopic therapy is empiric; a systematic approach to management of bile leak has not been established. METHODS: The severity of bile leak was classified by endoscopic retrograde cholangiography into low grade (leak identified only after intrahepatic opacification) or high grade (leak observed before intrahepatic opacification). Therapy was based on this distinction: biliary sphincterotomy alone for low-grade leaks and stent placement for high-grade leaks. The success of this strategy in consecutive patients treated between 1989 and 1999 was reviewed. RESULTS: A total of 207 patients (127 women, 80 men; median age 57 years) with bile leak were referred for endoscopic management; 134 had undergone laparoscopic, and 72 had open cholecystectomy. Patients presented at a median of 9 days (range 1-50 days) after surgery. Symptoms included pain (56%), jaundice (16%), fever (11%), and abdominal distension (7%). Persistent percutaneous drainage was present in 48%. Endoscopic retrograde cholangiography identified the leak site in 204 patients: cystic duct stump, 159 patients (78%); duct of Luschka, 26 (13%); other, 19 (9%). Of 104 patients with low-grade leaks, 75 had sphincterotomy alone; improvement occurred in 68 patients (91%). Subsequent treatment was required in 7 patients (6 stent, 1 surgery). Stents were placed in the remaining 29/104 patients for the following reasons: biliary stricture (11/29); coagulopathy, precluding sphincterotomy (8/29); severe sepsis (3/29); inadequate drainage after prior sphincterotomy (2/29); and unclear reasons (5/29). Of 100 patients with high-grade leaks, 97 had stent placement. Persistent leakage necessitated another stent insertion in 4 patients. Closure of the leak was documented by endoscopic retrograde cholangiography in all 97 patients. Three patients with leaks not amenable to endoscopic treatment were referred for surgery. Bile-duct stones were identified in 41 patients (28, low-grade group; 13, high-grade group) and were extracted in all cases. Overall, complications occurred in 3 patients (2 pancreatitis, 1 perforation) and were managed conservatively with no mortality. CONCLUSIONS: A simple, practical endoscopic classification system for bile leak after cholecystectomy is proposed. This classification has clinical relevance for selection of optimal endoscopic management.

Source: MEDLINE

Full Text: Available in fulltext at the ULHT Library and Knowledge Services' eJournal collection

32. Bile leak from the accessory biliary duct following laparoscopic cholecystectomy

Author(s): Pisanu A., Altana M.L., Piu S., Uccheddu A.

Citation: Il Giornale di chirurgia, April 2003, vol./is. 24/4(115-118), 0391-9005 (Apr 2003)

Publication Date: April 2003

Abstract: Anatomists and surgeons have described the presence of accessory biliary ducts between the liver and gallbladder. Bile leakage from accessory duct following postcholecystectomy.
laparoscopic cholecystectomy (LC) is an unusual post-operative complication. Aim of the study was to assess its incidence, the intraoperative methods helpful for notice the anatomical anomaly and the impact of endoscopic procedure as a suitable treatment. From January 1997 to September 2002, 185 patients underwent LC for symptomatic cholelithiasis in our surgical department. Post-operative bile leakage from accessory biliary duct occurred in two patients (1%): one case from the liver bed of gallbladder (duct of Luschka) and one case from an aberrant cholecystohepatic duct entering Hartmann's pouch. One patient underwent open celiotomy because of unavailability of endoscopic retrograde cholangiopancreatography. The other patient was successfully treated by endoscopic sphincterotomy and nasobiliary tube placement. By careful dissection, accessory ducts were noticed and clipped in three other patients with overall incidence of 2.7%. Meticulous laparoscopic technique aimed to careful recognize all structures during LC is the main policy to contain biliary injury within its nadir incidence. Depending of availability, endoscopic sphincterotomy and nasobiliary drainage allow diagnosis and treatment of bile leakage, preserving the effectiveness of laparoscopic procedure.

Source: EMBASE

37. Bile leak from the hepatic bed after laparoscopic cholecystectomy.

Author(s): Rossi P, Servili S, Contine A, Lucaroni Elena, Graziosi L, Carbone E, Annesi M, Framarini M, Tristaino B

Citation: Chirurgia Italiana, July 2002, vol./is. 54/4(507-9), 0009-4773;0009-4773 (2002 Jul-Aug)

Publication Date: July 2002

Abstract: The aim of our study was to identify the best treatment for bile leakage from the gallbladder or hepatic bed as a result of laparoscopic cholecystectomy. Two hundred and fifty laparoscopic cholecystectomies were performed in our department from January 1997 to January 1999 and bile leak was identified in 5 cases (2%). In one case, a right subphrenic collection was detected and resolved with a percutaneous drainage. At ERCP all cases showed a small leak from an accessory hepatic duct (2 pts.) or from the hepatic bed (3 pts.), successfully managed with an immediate endoscopic sphincterotomy, with placement of a nasobiliary tube or a biliary endoprosthesis. The incidence of leakage from an accessory hepatic or from Luschka's duct is not well known. This complication can be successfully managed with endoscopic treatment.

Source: MEDLINE


Author(s): De Palma GD, Iuliano GP, Puzziello A, Manfredini S, Masone S, Persico G

Citation: Minerva Chirurgica, April 2002, vol./is. 57/2(123-7), 0026-4733;0026-4733 (2002 Apr)

Publication Date: April 2002

Abstract: BACKGROUND: Significant postoperative bile leaks occur in approximately 0.8 to 1.1% of patients. The goal of endoscopic therapy is to eliminate the transpapillary pressure gradient, thereby permitting preferential transpapillary bile flow rather than extravasation at the site of leak. METHODS. Sixty-four patients were retrospectively evaluated. Endoscopic treatment comprised endoscopic sphincterotomy followed by insertion of a naso-biliary drainage or a stent. Retained stones were extracted by standard procedures.RESULTS: The cystic duct remnant was the site of bile extravasation in 50 cases, ducts of Luschka were the source in 4 cases, common bile duct in 6 cases and common hepatic duct in 4 cases. Retained bile duct stones were detected in 21 cases and papillary stenosis in 4 cases. Endoscopic therapy involved sphincterotomy in 25 cases with stones extraction in 21 cases followed by nasobiliary drain insertion, and placement of stent in the remainder. Bile leaks resolved in 96.9% of patients, on average 3 days in cases of associated stones or papillary stenosis, and 6.5 days in the remainder. Two cases of mild pancreatitis were evidenced from endoscopic treatment.CONCLUSIONS: Endoscopic management is the treatment of choice for postcholecystectomy bile leaks.

Source: MEDLINE
A 12-year-old boy with a primary diagnosis of hereditary spherocytosis and jaundice was referred after repeated episodes of pain in the right upper quadrant. In the medical history, he had undergone a laparotomy for splenectomy 5 years before and a thoracotomy for removal of a ...
demonstrates a small biliary leak from a Duct of Luschka that was not identified at the time of laparoscopic cholecystectomy (Fig. 13, ar- row). This patient had Cited by 15 - Related articles - Find@The Christie - All 3 versions

Management of Patients Who Return to the Hospital with a Bile Leak After Laparoscopic Cholecystectomy

JH Kim, WH Kim, JH Kim, BM Yoo… - … of Laparoendoscopic & …, 2010 - liebertonline.com

... Twenty-four patients, who presented with bile leaks or bile duct injury after a cholecystectomy, were identified, including 7 major and 17 minor injuries. ... (Ab) ERCP revealed a bile leak at the duct of Luschka 10 days after the LC, and a nasobiliary stent was inserted in the right ... Cited by 1 - Related articles - Lancashire Teaching Hospitals - Find@The Christie - All 2 versions

Evaluation and Treatment of BiliaryLeaks after Gastrointestinal Surgery

GC Vitale... - Journal of Gastrointestinal Surgery, 2011 - Springer

... Cystic duct stump leaks and duct of Luschka leaks are the first and second most common causes of bile leaks post- cholecystectomy. ... The incidence of biliary leak is higher with laparoscopic than with open cholecystectomy. ... Lancashire Teaching Hospitals - Find@The Christie

Biliary tract injury in laparoscopic cholecystectomy: Results of a single unit

Lancashire Teaching Hospitals M Miroshnik, A Saafan, S Koh... - ANZ Journal of …, 2002 - Wiley Online Library

... All seven patients with biliary leak showed chronic cholecystitis only on histopathology. ... Table 3. Avoiding bile duct injury in laparoscopic cholecystectomy. ... The subvesical duct of Luschka is a small duct of 1−2 mm diameter that is most frequently encountered in the centre of the ... Cited by 7 - Related articles - The Christie Online Journals - BL Direct - All 4 versions

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Bile duct of luschka leading to bile leak after cholecystectomy

by K Sharif - 2003 - Cited by 13 - Related articles
Volume 38, Issue 11, November 2003, Pages E21-E23 .... In case of established bile leak from a duct running in the gallbladder fossa, ... Post-laparoscopic cholecystectomy bile leak secondary to an accessory duct of Luschka. ... linkinghub.elsevier.com/retrieve/pii/S0022346803005980 - Similar

Bile leaks from the duct of Luschka (subvesical duct): a review

by CP Spanos - 2006 - Cited by 19 - Related articles
Table 1 Published series of patients with postcholecystectomy bile leak, subvesical duct leak, diagnostic modality ..... Mori S, Kasahara M (2001) Papillary adenocarcinoma of the ... Aduna M, Larena JA, Martin D et al (2005) Bile duct leaks after ... Sharif K, De Ville de Goyet J (2003) Bile duct of Luschka leading ... www.springerlink.com/index/W0T650574X467T97.pdf - Similar

Bile Leak from the Duct of Luschka Galleleck bei Luschka-Gang

by H Neumann - 2010 - Related articles
1 Bile leak originating from a branch of the right hepatic duct or duct of Luschka, ... 1 Spanos CP, Syrakos T. Bile leaks from the duct of Luschka (subvesical duct): a review. Langenbecks Arch Surg 2006; 391: 441-447 ... patients with suspected
postcholecystectomy bile leak. Gastrointest Endosc 2005; 61: 269-275

**Biliary peritonitis for duct of Luschka bile leak after...**
by F. Rulli - 2007 - Cited by 1 - Related articles
E. Grasso ... Fig. 1 The examen, showing a leak from a duct arising from the right hepatic duct ... Spanos CP, Syrakos T (2006) Bile leaks from the duct of. Luschka (subvesical duct): a review. Langenbecks Arch Surg, 391:441–447 ...
www.springerlink.com/index/k7772n268501k420.pdf - Similar

**Intraductal and invasive adenocarcinoma of duct of Luschka ... - WJSO**
by M Jahan - 2009 - Cited by 1 - Related articles
Received: 30 September 2008. Accepted: 7 January 2009 .... Like duct of Luschka, cholecystectomy may result in inadvertent injury to a cystohepatic duct and bile ... Mori S, Kasahara M: Papillary adenocarcinoma of the subvesical duct. ... Jenkins MA, Ponsky JL, Lehman GA, Fanelli R: Treatment of bile leaks from the ...
www.wjso.com/content/7/1/4 - Cached - Similar

**Bile Duct of Luschka Connecting with the Cystohepatic Duct: The...**
by T Aoki - 2003 - Cited by 8 - Related articles
In general, the bile duct of Luschka is a thin, short, vestigial bile duct lying in ... At surgery, unexpected bile leakage occurred when the gallbladder was ... After cholecystectomy, the common hepatic duct and the aberrant hepatic duct ... bed but does not enter the gallbladder lumen (a subvesical duct) [1, 3], ...
www.ajronline.org/cgi/content/full/180/3/694 - Similar

**Hepato-cystic Duct or Duct of Luschka - Bombay Hospital Journal**
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The Hepato-cystic duct of Luschka (HCDL), although a rare anomaly of the biliary ... The HCDL is a source of post cholecystectomy bile leak in 0.15% to 0.5% of all patients.5,10,12 ... bile leak. Gastrointest Endosc 2005; 61 (2) : 269-75. ... Am J Surg 2001; 182 (2) : 88-91. Kondo S, Isayama H, Akahane M, et al. ... www.bhj.org/journal/2006_4801_jan/.../case_Hepato_162-165.html - Cached