

Comparative Study between Laparoscopic Common Bile Duct Exploration and Endoscopic Retrograde Cholangiopancreatography Plus Laparoscopic Cholecystectomy for Choledocholithiasis

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Abstract

Background: Overall, 5% to 15% of patients undergoing cholecystectomy for cholelithiasis have concomitant bile duct stones, and the incidence of choledocholithiasis increases with age. Endoscopic Retrograde Cholangiopancreatography (ERCP) with consequent Laparoscopic Cholecystectomy (LC) has been the favored approach for the treatment of choledocholithiasis for quite a long time; however in the course of recent years, Laparoscopic Common Bile Duct Exploration (LCBDE) has been offered to patients with suspected choledocholithiasis.

Aim of Study: The aim of this work is to compare the efficacy, safety, and the surgical outcomes of LCBDE with ERCP followed by laparoscopic cholecystectomy and determine the most appropriate approach for patients with choledocholithiasis.

Patients and Methods: A prospective randomized clinical study was carried out from March 2017 to September 2018. It included 50 patients with cholecysto-choledocholithiasis who were divided into two groups: Group A (25 patients) included patients who underwent laparoscopic transcystic common bile duct exploration and stone extraction with LC in one stage, and Group B (25 patients) included patients who underwent endoscopic retrograde cholangiopancreatography for CBD stone extraction followed by LC in two stages. The Common Bile Duct (CBD) stone clearance rate, post-operative bile leakage, post-operative morbidity, mortality, overall hospital stay, and patient satisfaction were analyzed.

Results: LCBDE and ERCP+LC were similar in terms of clearance rate, operative time postoperative complications, retained CBD stones, and postoperative length of stay, but there was a significant difference in number of procedures and patient satisfaction.

Conclusion: Although both approaches have equivalent success rates, LCBDE is better in terms of fewer procedures, and better satisfaction compared with ERCP + LC. Our study suggests that one-stage management is the treatment of choice for patients with cholecystocholedocholithiasis.

Key Words: Bile duct stones – Laparoscopic common bile duct exploration – Laparoscopic cholecystectomy – Endoscopic retrograde cholangiopancreatography.

Introduction

IN general, 5% to 15% of patients experiencing cholecystectomy for cholelithiasis have corresponding bile duct stones, and a little rate of patients will develop CBD stones after cholecystectomy. Frequency of choledocholithiasis increments with age. Around 20% to 25% of patients more established than age 60 with symptomatic gallstones have stones in the CBD and in the gallbladder [1]. Subsequently, bile duct stones and their treatment constitute an imperative clinical issue. The essential objective in administration of choledocholithiasis is to get complete clearance of the common duct and cholecystectomy, when shown [2]. Alternatives for management of Common Bile Duct Stones (CBDS) are expanding with advancement of new innovations for conclusion and treatment. Management of symptomatic or unexpectedly found choledocholithiasis is still dubious. There is no evident agreement on the best restorative approach (endoscopic versus surgical) [3].

Pre-operative endoscopic retrograde cholangiopancreatography and Endoscopic Sphincterotomy (ES) are safe and successful choices for evacuating CBDS as a rule, yet not withstanding when clinical, biochemical, and ultrasound criteria are utilized; just 10% to 60% of patients will have stones on ERCP. Accordingly, extremely numerous superfluous ERCP are being performed. Truth be told, one of the best preventive measures to diminish ERCP confusions is not to perform it on the off chance that it is superfluous [4]. Utilization of intraoperative ERCP has gradually expanded among different

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endoscopic gatherings, in light of the fact that the move of ERCP from the Endoscopy Unit to the operating room has a short learning curve (endoscopic gatherings with mastery in pre-operative and post-operative ERCP) without the high specialized necessities required by laparoscopic administration of the bile duct [5,6].

Laparoscopic Common Bile Duct Exploration (LCBDE) was presented more than 15 years back and different surgical gatherings have demonstrated that it has a high achievement rate and is similarly as productive and protected as pre-operative or postoperative ERCP related with Laparoscopic Cholecystectomy (LC), in this way staying away from the need to play out extra methods [7,8]. After LCBDE, primary closure or T-tube drainage will be connected by the state of CBD and experience of surgeon. In 1991, Phillip initially announced the procedure of LCBDE and T-tube drainage in treatment of CBD calculi experienced amid laparoscopic cholecystectomy [9]. In recent years, there have been many articles published about the efficacy and safety of LCBDE compared with ERCP [10,11].

Material and Methods

This prospective clinical study was carried out from March 2017 to September 2018. It included 50 patients with concomitant GB stones and CBD stones who were divided into two equal groups: Group A (25 patients) underwent LTCBDE and LC in one stage, and Group B (25 patients) underwent ERCP for CBD stone extraction followed by LC in two stages. The study was approved by the Local Ethics Committee and conducted in accordance to the Helsinki II Declaration. An IRB form and written consent form was obtained from all patients after detailed explanation of the procedures and its possible complications. The main inclusion criteria were classic biliary-type pain, ultrasonographic demonstration of cholecystolithiasis, common bile duct diameter more than 6mm (>5mm up to 50 years, then 5 + 1mm per decade) by ultrasonography or demonstration of CBD stones by USG or MRCP or EUS, intrahepatic duct dilation as determined by ultrasonography or CT scan, platelet count more than 100000 103/ μ L and prothrombin time less than 3sec. of control. The main exclusion criteria were evidence of cholangitis and pancreatitis, evidence of cirrhosis, liver mass or abscess, neoplasm, suppurative or necrotizing cholecystitis, gallbladder empyema, or perforation.

All patients of our study were evaluated clinically before the operation and underwent standard

laboratory investigations (complete blood count, prothrombin time, partial thromboplastin time, international normalized ratio, liver function tests, serum amylase, and lipase), as well as radiological study, including abdominal ultrasonography, MRCP and EUS that were performed for patients with suspected CBD stones (elevated bilirubin and liver enzymes or ultrasound suspicion of CBD stones).

The operative technique in Group (A):

Prophylactic broadspectrum intravenous antibiotics with third generation cephalosporin was given at the time of induction. Routine 4 port Reddick laparoscopic cholecystectomy was performed using open method for induction of pneumo-peritoneum. Insertion of the umbilical port by infra-umbilical incision using the Hasson technique to introduce 10mm port was done, then introduction of CO₂ pneumoperitoneum maintaining the pressure at 12-15mm-Hg. This was followed by insertion of another three ports, 10mm epigastric port and two 5mm ports one just lateral to rectus muscle at right midclavicular line opposite to fundus and the other port at right anterior axillary line at the level of the umbilicus.

After identification of cystic duct and artery was done, intra operative ultrasound was performed to check the integrity of the common bile duct. The Laparoscopic Ultrasound (LUS) probe was inserted through the umbilical or the epigastric port Fig. (1). A distal clip was applied to the duct near the gall bladder neck securing the infundibulocystic junction. A small incision in the cystic duct was performed near to the clip using laparoscopic micro-scissors and the duct milked using the blades of Maryland forceps to ensure clearance of cystic duct from stones. The cystic duct was dilated by the tip of Maryland, then cannulated using a front tipped, saline flushed, size 5 ureteric catheter introduced through a cholangioclamp then screened with a C-arm during the injection Fig. (2).

After confirmation of choledocholithiasis was done and according to Table (1) we proceed to transcystic approach Figs. (3,4) or choledochotomy approach Figs. (5,6).

Transcystic approach Figs. (3,4):

The catheter was removed and a dilator (through the epigastric port) into the cystic duct and dilatation of the cystic duct was carried out. Instrumental stone extraction was performed using a three-wire soft Dormia basket under fluoroscopic guidance (safer for ensuring stone capture and avoiding instrumental CBD injury) or under visual cholangioscopic guidance (especially for small stones).

The assessment of complete stone clearance is performed in by control cholangiography or by using the flexible choledochoscope.

Choledochotomy approach Figs. (5,6):

The anterior wall of the CBD was additionally dissected within the porta hepatis, by using blunt dissection (avoiding the use of electrocautery close to the CBD). A longitudinal incision was made into the CBD after having blown up the CBD with saline solution through the transcystic cholangiographic catheter. The size of the incision was dependent on the size of the largest CBD stones to be extracted from the CBD. Instrumental stone extraction and stone clearance assessment were done as transcystic approach. Primary CBD closure was done when there is no doubt about the complete CBD vacuity. External biliary drainage was done by using T-tube exteriorized through the site of the most lateral trocar. Closure of the choledochotomy is performed by using interrupted sutures with PDS 4-0 stitches. At the end of the suturing, a water-tightness test is employed by blowing the CBD through the TC cholangiographic catheter, before clipping the CD or through the T-tube. Thereafter, cholecystectomy was completed by dissecting the GB from its bed using diathermy hook. Drain was inserted in the subhepatic region. The patient was discharged at postoperative 2-3 days. Control cholangiography was done at postoperative day 10 to exclude a residual CBD stones or a biliary leak.

Technique of endoscopic stone extraction:

The procedure was performed with the patient under intravenous sedation. The ERCP procedure was performed with a side-viewing duodenoscope. Selective cannulation of the bile duct was achieved using a wire-guided sphincterotome and a hydrophilic guidewire. After guidewire assisted cannulation, a contrast dye was injected to confirm the presence of CBD stones. For extraction of the stones, a biliary sphincterotomy was performed

using a combination current of cutting and coagulation. The stones were extracted with the help of a Dormia basket or an extraction balloon Fig. (7). A check cholangiogram was performed to confirm complete clearance of the bile duct. The patients were kept under observation for 6-8h after the procedure. The patients were given preprocedure, oral, broad-spectrum antibiotics from the day before the procedure to 5 days after it. After endoscopic extraction of the CBD stones, the patients underwent LC in another session.

All of the patients were scheduled for post-operative follow-up at 1 week, 1, 6 months or at any time if symptoms developed. The presence of pain and its severity, condition of the wound, history of jaundice, and any other problems were noted. At 1-month follow-up, liver function tests and abdominal ultrasound were performed to assess the status of the CBD. The surgical times, surgical success rates, post-operative complications, retained common bile duct stones, post-operative lengths of hospital stay, pain score and satisfaction score were denoted for all patients in Group (A) and (B).

Statistical analysis:

Collected data were tabulated. Quantitative data were expressed by the mean ± standard deviation and qualitative data were expressed as number and percent (%). *t*-student test was used to compare numerical data and Chi-square test was used to compare qualitative data, and *p*-value was considered to be significant if it was <0.05.

Table (1): The indications of various approaches of LCBDE.

Transcystic (TC) approach	Choledochotomy approach
<ul style="list-style-type: none"> • A patent cystic duct • A limited number of stones • Small stone size (less than cystic duct size) • Stones located below CD-CBD junction • Adequate biliary anatomy of the CD-CBD junction (the ideal case is a perpendicular angle of insertion of CD into the CBD) 	<ul style="list-style-type: none"> • Dilated CBD more than 7-8mm • Accessible porta hepatis

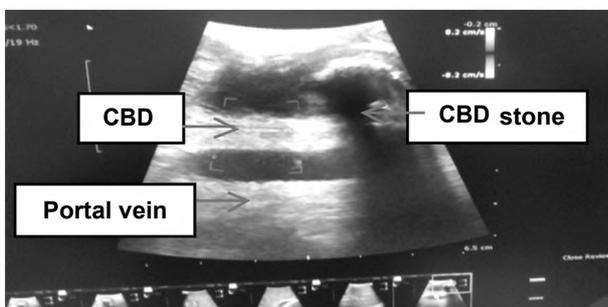


Fig. (1): LUS showing CBD hyperechoic stone with posterior acoustic shadow.

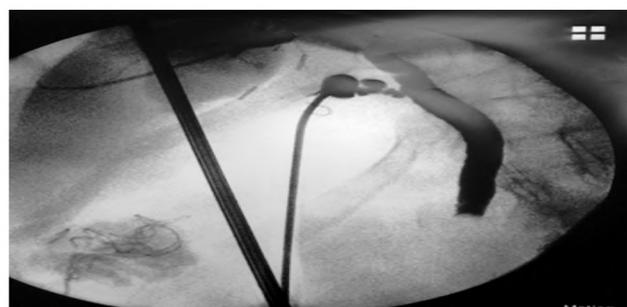


Fig. (2): IOC showing a filling defect in CBD.

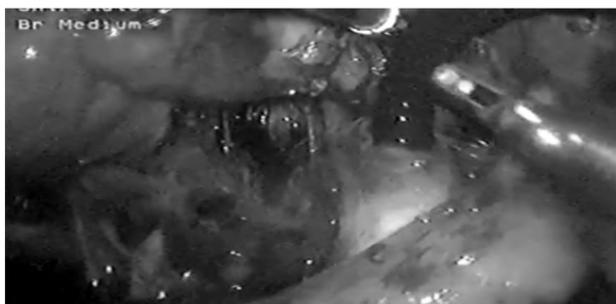


Fig. (3): Visualization of the CBD using the choledochoscope.



Fig. (4): Stone removal using the dormia basket.



Fig. (5): Gentle stone expression.

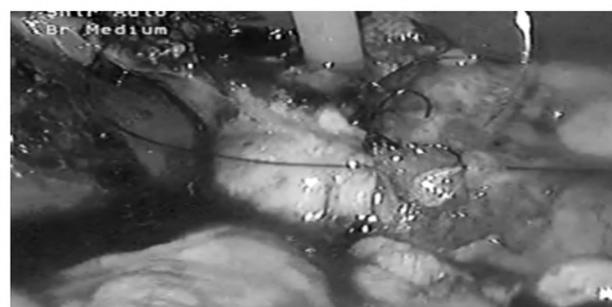


Fig. (6): Closure of CBD over T tube.



Fig. (7): Radiographic view of basket stone extraction.

Results

During the study period, March 2017 through Sep. 2019, a total of 50 patients were randomized for the treatment of CBD stones. 25 patients were randomized to LCBDE + LC (Group A) and 25 patients were randomized to ERCP + LC (Group B).

This study was carried out on 50 patients, 9 males (30%) and 41 females (70%). Their ages ranged between 21 and 70 years with a mean age of 47.24 years in Group (A), 44.76 years in Group (B). The most common clinical presentations in patients of this study are shown in Table (2).

There was disturbance in liver functions in most of cases, elevated serum bilirubin level was detected in 30 patients (60.0%), elevated alkaline phosphatase and Gamma Glutamyl Transaminase (GGT) levels in 35 patients (70.0%), elevated Serum Glutamic Oxaloacetic Transaminase (SGOT)

and Serum Glutamic Pyruvic Transaminase (SGPT) in 35 patients (70.0%). The results of the imaging studies were shown in Table (3).

Intraoperative cholangiography was done routinely for all patients of both groups and it revealed stones in 24 patients in Group (A) (96% sensitivity), and done for all patients in Group (B) before cholecystectomy and it didn't reveal stones in any patient.

The surgical results: Tables (4,5):

In Group (A), the procedures were completed in 21 cases (84%). Four cases of 25 (16%) were converted to open CBD exploration and stone extraction followed by T-tube and drain insertion. The T-tube was removed after 10 days following T-tube cholangiography, and the drain was removed on the next day. The reasons for conversion were dense adhesions (two patients), impacted stone (one patient) (the choledochoscope wasn't available) and bleeding (one patient).

One patient in Group A with a diagnosis of retained CBD stones was also considered as failure, This patient underwent LCBDE (choledochal approach + primary closure), she suffered from bile leak one week after surgery, abdominal ultrasound showed retained two CBD stones with no collections and she subsequently underwent successful ERCP and stone clearance. Thus, the actual success rate was 20 of 25 patients (80%).

In Group (B), ERCP was successful for 21 of 25 patients (84.0%). More than one attempt for complete clearance of the CBD was required for 3 patients (12%). This was followed by LC after six weeks. LC was completed for 19 of 21 patients (85.7%), and converted to open cholecystectomy in two cases (14.3%). The causes of conversion were bleeding (one case) and dense adhesions (one case). In the remaining 4 patients (16%), CBD stones could not be cleared by means of ERCP. The causes of ERCP failure were unsuccessful cannulation (one patient), inability to remove impacted CBD stones (one patient), impacted dormia basket (one patient). All of them underwent LCBDE and stone extraction with cholecystectomy and duodenal perforation (one patient). This patient suffered from small posterior duodenal perforation sealed spontaneously without surgical intervention. After one week this patient underwent LCBDE (choledochal approach) and stone extraction with cholecystectomy and insertion of T-tube and drain. The actual success rate for Group B was 19 of 25 patients (76%).

The overall success rate in both groups (80% in Group A vs. 76% in Group B; $p=0.60$). However, the average number of procedures per patient was significantly lower in Group A than in Group B (1.1 vs. 2.23; $p<0.001$).

Table (2): Shows the clinical presentations of studied patients.

Complaint [n (%)]	Group A	Group B	p-value
Right upper quadrant pain	21 (84%)	22 (88%)	Ns
Jaundice	8 (32%)	14 (56%)	0.15
Pruritus	5 (20%)	9 (36%)	0.34
Fever	2 (8%)	5 (20%)	0.41
Nausea and vomiting	7 (28%)	11 (44%)	0.37
Cholangitis	0	3 (12%)	0.23
Pancreatitis	0	2 (8%)	0.48

Table (3): Results of imaging studies done for studied patients.

Imaging studies	Group A	Sensitivity	Group B	Sensitivity	p-value
• <i>Ultrasound</i> [n]:					
CCC	25/25	100%	25/25	100%	Ns
Dilated CBD	19/25	76%	21/25	84%	0.72
CBD stones	19/25	76%	21/25	84%	
• MRCP [n]	12/13	92.3%	—	—	
• EUS [n]	11/12	91.6%	14/15	93.3%	Ns
• Max. size of CBD stones (mean ± SD) (cm)	0.91 ± 0.072		1.08 ± 0.072		0.35
• Single CBD stones [n]	9	—	11	—	0.77
• Multiple CBD stones [n]	16	—	14	—	

Table (4): Operative data of the studied patients.

	Group A	Group B	p-value
• Number of procedures per patient (mean ± SD)	1.040 ± 0.040	2.120 ± 0.0663	<0.0001
• Success rate	20 (80%)	19 (76%)	0.52
• Failure rate	5 (20%)	6 (24%)	
• Operative time (mean ± SD) (min)	199.2 ± 8.601		
• Intraoperative cholangiogram	25 (96% sensitivity)	226.4 ± 14.59	0.11
• Intraoperative ultrasound	15 (93% sensitivity)		
• Choledochoscope	20 (95% sensitivity)		

Table (5): Post-operative follow-up of the studied patients.

	Group A	Group B	p-value
• 24h pain score (mean ± SD)	6.120 ± 0.240	6.440 ± 0.238	0.34
• Hospital stay (mean ± SD) (days)	4.440 ± 0.798	4.920 ± 0.772	0.66
• Patient satisfaction score (mean ± SD)	6.60 ± 0.408	5.20 ± 0.428	0.02

Discussion

Bile duct stones are found in 7-20% of patients with symptomatic gallstones. The nearness of common bile duct stones essentially increases the morbidity, mortality, and expenses of patients with gallstones [12]. The management of CBD stones has experienced different phases of advancement and development, and LCBDE is currently viewed as a better procedure compared with endoscopic extraction of stones, with comparable morbidity and mortality and a shorter hospital stay in fit patients [13]. The undeniable objective of treatment in choledocholithiasis is to accomplish ductal clearance with the least number of mediations, most minimal expense and least morbidity [14].

Conventional surgical treatment involves intra-operative cholangiography to identify the presence of bile duct calculi pursued by choledocholithotomy and T-tube placement. For a long time this strategy offered successful treatment and was related with a morbidity rate of 10-15%, a death rate of <1% (in patients under 65 years) and a retained stone rate beneath 6% [15].

Although ERCP is effective and safe, this management option has several disadvantages, including a large number of normal ERCP's performed, up to 86% when ERCP is performed routinely for all patients and division of the choledochal sphincter in young adults, leading to loss of the normal physiologic barrier, with long term complications such as ampullary stenosis, duodenobiliary reflux, and recurrent stone formation [16].

It was reported that one stage operations have some benefits, as compared to two stage operations. Morbidity after one-stage operations was only 7.5% (2 times lower). The reported results of LCBDE when compared to data obtained after the two-stage procedure, show at least identical, rather improved safety for the patient and partial reduction of costs [17]. Postponing laparoscopic cholecystectomy post ERCP makes it difficult to be performed due to the possibility of adhesions at the area of Calot triangle this is in additional risk of second time anaesthesia [18].

Intraoperative cholangiography is an accurate method for detecting common bile duct stones and it helped us greatly in avoiding injury of the bile ducts. It was done for all patients of Group (A) before LCBDE and it revealed stones in 24 patients (95% sensitivity). Intraoperative ultrasonography was done for 15/25 patients of Group (A) before LCBDE and it revealed stones in 14 patients (93% sensitivity). These findings were similar to data collected from several studies which denoted that IOC (intraoperative cholangiography) has a sensitivity of 98% and specificity of 94% to detection of CBD stones [19].

The success rate for LCBDE in our study was 80%, which was comparable to that reported in the existing literatures (80-98.5%). Similar study carried out by Hong DF et al., denoted success rate of 80% [18]. In other studies success rate of 80% to 95% were reported [20-22].

Our study showed similar success rates for the single-stage and two-stage procedures (80 vs. 76%), but the single-stage procedure was better in terms of a less number of procedures and higher patient satisfaction compared with two-stage management. This is consistent with previous research reports [23,24]. To date, little agreement has been reached on the rate of CBD stone clearance. One meta-analysis of eight RCTs showed that LCBDE + LC was associated with a higher rate of CBD stone clearance than pre-ERCP + LC (90.17% vs. 85.71%, respectively; recent meta-analysis [25]. However, a study conducted by Elgeidie et al., showed that pre-ERCP + LC was associated with a higher success rate of CBD stone clearance [26].

There was only one case suffered from retained common bile duct stones among patients belonged Group A (4.5%). This was in contrary to 12% of studied patients in the study carried out by Stanley et al., [27]. In the study by Ding et al., the authors reported that LCBDE + LC stones had a lower recurrence rate [28].

In this study our favored technique for LCBDE was the transcholedochal approach and was done for nineteen patients while the transcystic approach was done for six patients as the transcystic approach needs specific cystic duct and stones characters as in (Table 1). The postoperative course after successful transcystic clearance is similar to laparoscopic cholecystectomy alone. This was in agreement with the following studies [8,29].

In this study we used the choledochoscope for twenty patients and it was helpful to confirm bile duct clearance and to visualize the proximal portion of the CBD with sensitivity (95%) In the other five cases choledochoscope was replaced (due to some technical problems in the choledochoscope) by fluoroscopic guidance and confirmatory IOC. This was in agreement with Phillips EH et al., who denoted nearly similar efficacy between choledochoscope and fluoroscopic guidance [30]. This was in contrary to Topal B et al., who reported that the use of a flexible choledochoscope is preferable to fluoroscopic guidance [31].

In our study T-tube drainage was done for 10 cases while primary closure was done for 6 cases with no statistical difference between them. This is in agreement with recent studies which show that primary sutures have the same safety and effectiveness as T-tube drainage. This is still controversial. More detailed and higher-quality research on postoperative pancreatitis and bile leakage is necessary in the future [32].

In our study ERCP was successful for 21 of 25 patients (84.0%). More than one attempt for complete clearance of the CBD was required for 3 patients (12%). This was followed by LC after six weeks. LC was completed for 19 of 21 patients (85.7%), and converted to open cholecystectomy in two cases (14.3%). The actual success rate for Group (B) was 19 of 25 patients (76%). However other studies denoted that the overall success rate of ERCP/S + LC in experienced hands is well established at about 95%. However, the minimum number of ERCP procedures necessary for competency has been suggested by Vitale et al., to be between 102 and 185 procedures to achieve a success rate of 85% to 90% [33].

Our study reported that five patients in Group B were converted from LC to open cholecystectomy following successful ERCP due to adhesions and uncontrollable bleeding. This is similar to Allen and Leeth and Donkervoort et al., who reported greater difficulty and higher conversion rates with chole-

cystectomy after ERCP and the possibility of unpredictable adhesions [34,35].

The mean operative time was shorter in Group (A) than in Group (B) in our study (199.2 ± 8.6 vs. 226.4 ± 14.5) with no significant difference ($p=0.114$). This was similar to previous studies that showed similar results [36,37].

Our study showed no significant difference between Group A and Group B regarding post-operative complications (8% vs. 16%; $p=0.66$). The complication rates in the literature have not differed significantly between the two strategies. A meta-analysis found the morbidity rates to be 19% in the single-stage group and 15.2% in the two stage group, and the difference was not statistically significant [38].

Our study showed no significant difference between Group (A) and Group (B) regarding hospital stay (4.44 ± 0.79 vs. 4.92 ± 0.77 ; $p=0.66$) and 24h pain score (6.12 ± 0.24 vs. 6.44 ± 0.23 ; $p=0.34$). This is in contrast to other studies which denoted shorter hospital stay in this Group A than Group B [18,32,39].

Conclusion:

Although both treatment methods have equivalent success rates, the one-stage management is better in terms of fewer procedures, and better overall satisfaction compared with the two-stage approach. In addition, the one-stage management also avoided the risks associated with ERCP and sphincterotomy and kept the sphincter of Oddi intact, and this was associated with a lower risk for late CBD stone formation. Hence, the outcomes of this study suggest that the one-stage management is the treatment of choice for patients with concomitant GB and CBD stones, especially in younger patients who have longer period of risk for recurrence of CBD stones.

Conflict of interest:

We declared that there is no conflict of interest.

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دراسة مقارنة بين منظار القنوات المرارية المتبع بإستئصال الحويصلة المرارية وإستكشاف القناة المرارية بالمنظار الجراحي لعلاج تحصى القنوات المرارية

تعتبر حصوات الحويصلة المرارية أكثر أسباب آلام البطن شيوعا، حيث تصيب حوالي ٣٠٪ من البشر فوق ٧٠ عام، حوالي ١٠٪ من مرضى حصوات الحويصلة المرارية يفضلون عدم إستئصال الحويصلة المرارية ودون حدوث أى مضاعفات. من أهم أسباب تكون حصوات الحويصلة المرارية التاريخ العائلي، داء السكري، الحمل، السمنة، إنخفاض الوزن الملحوظ، وأمراض إنحلال الدم. وما يصل إلى ٣٥٪ من مرضى حصوات الحويصلة المرارية يعانون من نهاية المطاف من أعراض تتطلب إستئصال الحويصلة المرارية.

يعتبر المغص المرارى، إلتهاب الحويصلة المرارية الحاد، إلتهاب البنكرياس الناتج عن وجود حصوات، إنسداد القناة المرارية العامة وإلتهاب القنوات المرارية الناتج عنه من أهم المضاعفات الناجمة عن حصوات الحويصلة المرارية.

من أهم مضاعفات حصوات الحويصلة المرارية إنسداد القناة المرارية العامة حيث تصيب ١٠٪-٨٥٪ من هؤلاء المرضى، ويلاحظ ذلك بصورة شائعة فى الأعمار المتقدمة وخصوصاً فوق سن الخمسين.

يمثل إستئصال الحويصلة المرارية بالمنظار الجراحي الحل الأمثل لعلاج إلتهاب الحويصلة المرارية الحصوى، كما تغيرت طرق علاج حصوات القناة المرارية العامة لتشمل منظار القنوات المرارية، إستكشاف القناة المرارية العامة جراحياً أو بالمنظار. يتميز إستكشاف القناة المرارية العامة بالمنظار الجراحي بأنه إجراء من خطوة واحدة مقارنة بمنظار القنوات مرارية حيث يحتاج المريض لإستئصال الحويصلة المرارية بعد ذلك.

فى السنوات الأخيرة، كانت هناك العديد من المقالات التى نشرت حول فعالية وسلامة إستكشاف القناة المرارية العامة بإستخدام المنظار الجراحي مقارنة بمنظار القنوات المرارية.

يعتبر منظار القنوات المرارية ثم إستئصال الحويصلة المرارية بعد ذلك الحل الأمثل لعلاج إنسداد القنوات المرارية الحصوى. وخلال العامين الماضيين تم عمل إستكشاف للقنوات المرارية بإستخدام المنظار الجراحي لبعض المرضى كبديل لمنظار القنوات المرارية ولذلك فإن الغرض من هذه الدراسة هو المقارنة بين الطريقتين.