Introduction

Bile duct injury (BDI) represents a serious and challenging surgical complication. These complex injuries are most often a consequence of laparoscopic cholecystectomy (LC) [1] and are still a major problem in current surgical practice. BDI is associated with reduced survival, increased morbidity, and poor quality of life [2,3]. It is not clear whether the injury should be repaired immediately or the repair should be delayed [4].

Iatrogenic BDI (IBDI) may occur following several types of abdominal operations, for example, liver surgery, gastrectomy, common bile duct (CBD) exploration, etc., and can be associated with life-threatening complications. However, the majority of IBDIs result from open cholecystectomy or LC [5]. The incidence of BDI at LC has been reported to be between 0.3 and 1.4% [6]. Only 30% of injuries are recognized at the time of operation. Measures to prevent and recognize BDI are outlined in many publications [7–9]. Preoperative management of BDI ranges from simple drainage and referral to a tertiary center to an end-to-end anastomosis (EEA), with or without T-tube drainage and hepaticojejunostomy [10]. However, EEA is considered to be a relatively simple definitive repair, and it is also an optimal initial drainage procedure before reconstructive surgery in a secondary setting [11].

The classic injury occurs in the CBD, resulting in clipping and division of the common duct, which is then resected with the gallbladder [12]. Opting for laparotomy is not to be considered to be a failure but rather a good surgical decision that ensures the patients’ safety [13].

BDIs can occur during difficult reconstructions, even when carried out by experienced surgeons, and are associated with prolonged hospital stay and a high risk of long-term complications. Roux-en-Y hepaticojejunostomy has been the most commonly used approach for biliary reconstruction, especially in cases of duct transaction injury [14]. However, its long-term outcome is still far from satisfactory.
because of the high incidence of reflux cholangitis, choleodocholithiasis, and anastomotic stenosis [15].

In the recent years, primary duct-to-duct reconstruction has been used in living donor liver transplantation and has gained good effects [16–18]. It preserves the function of the Oddis sphincter, which serves as a barrier to prevent any reflux into the bile duct [19].

The aim of this study was to introduce a new surgical technique for primary repair of BDI by placement of a plastic stent tube [stent used in endoscopic retrograde cholangiopancreatography (ERCP)] in the bile duct, and to compare its results with those of Roux-en-Y hepaticojejunostomy.

Patients and methods
This was a prospective study of patients with a clinical diagnosis of BDI, referred to the Department of General Surgery, Faculty of Medicine, Al-Azhar University, and the El Harm Hospital over a 5-year period between January 2008 and January 2013.

During the study period, a total of 34 patients with BDI were enrolled. Among them, 10 (30.1%) were male and 24 (69.1%) were female. Their ages ranged from 20 to 70 years, with a mean age of 40.84 years. All patients presented with BDI in the early postoperative stage after surgery (within the first few weeks). The main presentations were jaundice (82%), bile leak (15%), and other symptoms (3%).

Careful history taking, clinical examination, laboratory investigations, and liver function tests to estimate the levels of bilirubin, alanine aminotransferase, and aspartate aminotransferase were carried out. Abdominal ultrasonography, CT scanning of the abdomen, and ERCP or magnetic resonance cholangiography (MRC) were also performed. All patients were admitted to the Surgical Department after failure of endoscopic management.

Surgical procedure
Prognosis of surgical management depends on the timing of recognition of the injury, time of surgery, type of injury, patient’s condition and available facilities, and the surgeon’s expertise.

Operative procedures and guidelines for the treatment of BDI are presented in Table 1. The 34 patients were divided into two equal groups: group A underwent primary repair of the bile duct with placement of a plastic stent (which is used in ERCP) and group B underwent Roux-en-Y hepaticojejunostomy.

![Figure 1](complete_ligation_of_the_distal_common_bile_duct_with_no_filling_of_the_proximal_common_bile_duct.jpg)

**Figure 1**
Complete ligation of the distal common bile duct with no filling of the proximal common bile duct.

**Table 1 Guidelines for the treatment of BDI**

<table>
<thead>
<tr>
<th>Guidelines for the treatment of BDI</th>
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<tr>
<td>Exposure of damaged area, avoiding too much dissection</td>
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<tr>
<td>The end of the injured bile duct has to free from burnt areas</td>
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<tr>
<td>Intraoperative cholangiography in every bile leakage</td>
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<tr>
<td>Vascular integrity should be confirmed</td>
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<tr>
<td>The CBD was reconstructed by EEA after stent placement.</td>
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<tr>
<td>Roux-en-Y hepaticojejunostomy is recommended if a part of the bile duct is lost</td>
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<tr>
<td>Opposition of both mucosa with absorbable sutures</td>
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<td>Use of magnification (if available)</td>
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BDI, bile duct injury.
Management of bile duct injuries

Management of bile duct injuries

characteristics, management, and outcome are expressed as number of patients and percentages, with a significance level of \( P \) less than 0.05.

Results

BDIs are infrequent but potentially devastating complications that have become more common since the introduction of LC. The successful management of these injuries depends on the injury type, the timing of its recognition, the presence of complicating factors, and the condition of the patient. There was neither intraoperative death nor bile leakage detected during the observation period in both groups of our study.

BDIs in these patients were divided on the basis of the mechanism and anatomy of the injury into four classes using the Stewart–Way classification (Fig. 5):

Operative procedure for group B

During LC, CBD was misidentified for subverted anatomy caused by inflammation. The CBD was clipped, and the patient presented with jaundice 3 days after the operation. ERCP was performed showing the stop, and MRC was performed showing ligation of the right and left hepatic ducts (Fig. 3). Therefore, reoperation was needed and intraoperatively, showed clipping CBD with burned common hepatic duct, above the level of cystic (class iii Stewart –Way classification), Roux-en-Y hepaticojejunostomy was performed with complete recovery (Fig. 4).

Surgical outcome

The patients were assessed preoperatively, intraoperatively, and postoperatively. Conservative charting and clinical evaluation, estimation of the level of bilirubin on liver function tests, ultrasonography of the abdomen, and MRC to detect biliary continuity were carried out. Follow-up examinations were carried at outpatient clinics (3–12 months).

Statistical analysis

Statistically analysis was carried out using SPSS (SPSS Inc., Chicago, Illinois, USA). Data on patient

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Figure 2

(a) Stent draining bile duct. (b) Polyethylene biliary stents are soft and pliable and conform ideally to the anatomy of the bile duct. The specific design facilitates easy insertion and allows for optimal drainage flow.

Figure 4

(a) Side-to-side hepaticojejunostomy: absorbable 5-0 monofilament interrupted stitches leaving the knots outside the anastomotic lumen. (b) Roux-en-Y hepaticojejunostomy.

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Figure 3

Magnetic resonance cholangiography (MRC) revealed bile duct injury (BDI), with right and left hepatic duct ligation and common bile duct cross-section.

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Figure 5

The Stewart–Way classification of laparoscopic bile duct injuries. Class I, incision (incomplete transection) of the common bile duct (CBD); class II, lateral damage to the common hepatic duct (CHD); class III, transection of the CBD or CHD; and class IV, right hepatic duct or right segmental hepatic duct injuries.
class I, incision (incomplete transection) of the CBD \( [n = 6 \ (17.6\%)] \); class II, lateral damage to the common hepatic duct \( [n = 9 \ (26.5\%)] \); class III, transection of the CBD or common hepatic duct \( [n = 15 \ (44.1\%)] \); and class IV, right hepatic duct or right segmental hepatic duct injuries \( [n = 4 \ (11.8\%)] \).

**Patient characteristics**

Patient characteristics are presented in Table 2. There were no significant differences in age, sex, or cause of biliary injury among patients.

All patients were treated by primary repair of BDI by biliary stent therapy; a successful outcome was obtained in 15 of 17 patients, with no sign of stenosis or leakage. However, two patients required surgical revision (because of stent migration) using the Roux-en-Y technique. It was also significantly longer for time of operation (2–4 to 3–6 h), hospital stay (5–8 to 10–42 days), Cost-effectiveness and Safety, but postoperative complications include (postoperative sepsis, surgical site infection, and wound dehiscence) and biliary-specific complications is not significant (Table 3).

**Discussion**

BDI is a major complication of biliary surgery. It can be classified according to the injury site using several classification systems, for example, Bismuth classification [11], Strasberg classification [8], and Stewart–Way classification of laparoscopic BDIs [20].

Maintaining biliary continuity and integrity of function is essential in biliary reconstruction. Roux-en-Y hepaticojejunostomy has been the most commonly used procedure for repairing CBD defects. However, the function of the Oddis sphincter was lost in patients undergoing this procedure, leading to a high incidence of postoperative reflux cholangitis [21]. In this procedure, the stent plays an important role. The stent is connected to two ends of the bile duct to maintain the continuity of the biliary structure, and it is also used as an inner stent to prevent anastomosis restenoses [22,23]. The blood supply for the biliary anastomosis is a major concern in duct-to-duct biliary reconstructions. Obtaining adequate blood supply is fundamental for technical improvements in biliary reconstruction [16].

The risk for increased damage is smaller in an EEA procedure, and with the use a T-tube instant bile drainage is realized. If indicated, reconstructive surgery by elective hepaticojejunostomy can be performed. The present study shows a long-term stricture free survival of 91% in EEA patients after treatment at a tertiary center. The analysis also shows that the majority of complications after primary EEA at a general hospital can successfully be treated by endoscopic and radiological interventions. In only one-third of the patients, a secondary surgical repair is necessary. Surgical reconstruction after EEA was associated with acceptable morbidity and was without mortality [10].

In a situation in which preoperative bile leakage is due to (extensive) tissue loss, particularly in patients with more proximal lesions at the bifurcation or intrahepatically, no primary repair should be performed. In this situation, adequate drainage of the upper right abdomen is strongly advised and the patient should be referred for elective reconstruction, which has a positive effect on outcome [3].

Patients with postoperative biliary leaks fare much better than those with complete cutoff or strictures, as 93% of patients with postoperative biliary leaks were managed successfully. Magnetic resonance cholangiopancreatography should be performed in all patients before surgery, and in the case of continuity with the proximal system, repeat ERCP should be performed. Further, re-exploration should be deferred until all other noninvasive modalities have been tried out. Of the 41 patients, five (12.2%) with bile leak developed biliary strictures on subsequent ERCP. Nine of the 15 patients (60%) with complete cutoff on initial

<table>
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<th>Table 2 Patient characteristics</th>
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<tr>
<td>Total patients ( (n) )</td>
<td>34</td>
</tr>
<tr>
<td>Age at operation ( \text{Mean (years)} )</td>
<td>20–70 (40.84)</td>
</tr>
<tr>
<td>Sex ( [n \ (%)] )</td>
<td>10 (30.9)/34 (69.1)</td>
</tr>
<tr>
<td>Presentation ( (%) )</td>
<td>82</td>
</tr>
<tr>
<td>Bile leak</td>
<td>15</td>
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<tr>
<td>Obstructive jaundice</td>
<td>3</td>
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| Table 3 Comparison between group I, which underwent primary repair of BDI, and group II, which underwent Roux-en-Y hepaticojejunostomy |  |
| Parameters                        | Group I | Group II | \( P \)-value |
| Operative time \( (h) \)          | 2–3     | 4–6      | 0.002        |
| Postoperative oral feeding \( (\text{days}) \) | 12.15 ± 3 | 97.1 ± 3 | 0.16         |
| Hospital stay \( (\text{days}) \)  | 1.47    | 57       | 0.550        |
| Return to work \( (\text{days}) \) | 14.40 ± 4 | 70.17    | 0.017        |
| Bile leak                         | 2 (5.0) | 1 (5.0)  | 0.017        |
| Superficial infection             | 0 (0.0) | 2 (10.0) | 0.014        |
| Postoperative cholangitis         | 3 (16.0)| 4 (20.0) | 0.012        |

BDI, bile duct injury, Statistically significant: \( P \)-value 0.05.
endoscopy were successfully treated on subsequent ERCP after demonstration of biliary continuity on magnetic resonance cholangiopancreatography. Six (40%) patients were referred for surgery [23]. Endoscopic therapy is safe and effective in the management of postoperative bile duct leak. For postoperative bile duct strictures, ERCP is a less favorable option [24].

Liang et al. [25] created a novel method for CBD reconstruction, namely duct-to-duct anastomosis (Fig. 6). This technique was effective in repairing the defect, with a good short-term effect without postoperative bile duct stricture, proving its feasibility and safety. The management of BDI has become a hot topic in clinical studies. With the development of tissue engineering, several studies on biodegradable materials for the biliary duct have been conducted.

EEA is reported to be associated with a high incidence of recurrent jaundice due to stricture formation in the anastomotic area [26]. Therefore, some authors report that EEA is almost never appropriate if the bile duct has been completely transected [27]. Stent therapy for iatrogenic bile duct strictures has changed during the last decade, and therefore the long-term outcome after stenting has improved [28]. The only severe complication that occurred in the present series, due to stent migration, was not reported in previous series [29]. Determining the optimal procedure for biliary construction is an important surgical issue. Scatton and colleagues reported a lower incidence of overall biliary complication in the T-tube group. However, the most frequent complication was leakage after T-tube removal, whereas the incidence of anastomotic stricture was greater in the group without a T-tube [30].

Short-term and long-term results of reconstructive methods and quality of life of patients treated for IBDIs with Roux-en-Y hepaticojejunostomy or EEA were compared. Complications occurred earlier after hepaticojejunostomy [31]. Plastic biliary end prostheses have not changed much since their introduction more than three decades ago. Although their use has been challenged by the introduction of metal stents, plastic stents still remain commonly used. Much work has been carried out to improve the problem of stent obstruction, but without substantial clinical success. In this review, the authors discuss the history of plastic biliary stent development and the current use of plastic stents for malignant biliary diseases [32].

We performed a retrospective case review of patients who were referred for ERCP after traumatic BDI secondary to blunt (motor vehicle accident) or penetrating (gunshot) trauma for management of bile leaks. Fourteen patients underwent ERCP for the management of a traumatic bile leak over a 5-year period. All patients were treated by biliary stent placement, and the outcome was successful in all patients (100%). The mean duration of follow-up was 85.6 days (range 54–175 days). There were no ERCP-related complications. On the basis of our study results, ERCP should be considered as first-line therapy in the management of traumatic bile leaks [33].

Pauswasadi et al. [34] reported that full cover self-expandable metal stents may be a reasonably good alternative treatment option for difficult benign biliary strictures and bile leaks. The current data, however, do not demonstrate the superiority of full cover self-expandable metal stent placement over plastic stent placement (Fig. 7). Randomized controlled studies...
establishment of bilioenteric continuity. It also replaced the drawbacks of Roux-en-Y hepaticojejunostomy, and allowing nonphysiological re-vascular injuries. Twelve cases (71%) were converted to open surgery. The repairs included 10 primary biliary closures, four Roux-en-Y hepaticejunostomies, end-to-end anastomosis, and one laparoscopic transpapillary drainage. Postoperative complications occurred in five patients (29.4%). During the follow-up period, early biliary strictures developed in two patients (11.7%) and were treated by percutaneous dilation and Roux-en-Y hepaticojejunostomy with satisfactory long-term results [35].

Surgery remains the choice in CBD transection, ligation, and combined injuries of stones, strictures, and leakage in 60% of cases. Bilioenteric anastomosis was the procedure of choice. The learning curve seems influential in both endoscopy and surgery. Cumulative experience increased the success of endoscopy from 60 to 95%. In addition, surgery improved, with decreased morbidity and mortality. In conclusion, endoscopy is comparable to surgery during the initial treatment of simple problems, but for major leaks, ligation, transection, and complex problems, surgery is the main treatment option because of its invasiveness [36].

In view of the high rate of success and low incidence of complications in the CBD, it became the gold standard in the treatment of BDI. However, once again, it should be stressed that good results can be obtained only by careful selection of patients in association with surgical experts from among those in whom ERCP, which is considered as first-line therapy in the management of BDI, failed.

**Conclusion**

Surgical treatment of BDI by primary repair of the bile duct by stent placement shows good results, involving minimal morbidity, operative time, hospital stay, and cost; avoiding the drawbacks of Roux-en-Y hepaticejunostomy, including high risk of contamination due to construction of the Roux-en-Y limb, and allowing nonphysiological re-establishment of bilioenteric continuity. It also replaced exploration of CBD using a T-tube, with more advantages of using a plastic tube. It is also of importance to preserve the function of the Oddis sphincter, which may reduce the risk of enteric reflux into the biliary tract. The stent played an important role in maintaining continuity of the biliary structure and preventing anastomosis restenoses.

**Acknowledgements**

**Conflicts of interest**

None

**References**

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Khalaf


