SHORT COMMUNICATION

Current palliative treatment of malignant jaundice

Hutan M, Salapa M, Poticny V, Bandzak J

Department of Surgery, Faculty of Medicine, Comenius University, Hospital Ruzinov, Bratislava, Slovakia. ***bll@fmed.uniba.sk***

Abstract

When selecting the most suitable palliation of malignant jaundice, the following factors are to be considered: 1) patient's overall condition, 2) presumption of patient's survival, 3) technical, personal, and economic factors, 4) effectiveness of procedure, 5) morbidity and mortality of palliative treatment. ***(Tab. 2, Ref. 3.)***
Key words: palliative treatment, malignant jaundice, carcinoma, metastasis.

Approximately eighty per cent of tumors in bile tract area cannot be solved by radical surgical procedures. Jaundice as a result of malignant obstruction carries the danger of hemorrhage, hepatorenal malfunction and cholangoitis followed by sepsis. In addition to the latter facts, jaundice itself causes such suffering, that palliative action or even basic outer drainage means enhancement of the life's rest. There are surgical, endoscopical, and radiological methods to be used in palliative treatment of jaundice. Surgical derivations' choice are: 1) cholecystostomy, 2) "T" drainage of hepatocholedochus, 3) diahepatical U shape drainage, 4) malignant stenosis surgical intubation, 5) choledochoduodenostomy, hepaticoduodenostomy, 6) cholecystoduodenostomy, cholecystojejunostomy, 7) hepaticojejunostomy, 8) intrahepatical jejunostomy.

Material and methods

This work analyses retrospectively the patients with malignant jaundice treated at our department. In the years 1996–2000, there were 83 endoscopical retrograde cholangiopancreaticographies (ERCP) with the finding of malignant stenosis of bile tract performed at the endoscopical part of Internal Medicine Department of Medical Faculty, Hospital Ruzinov, Bratislava. The majority of cases were caused by tumor of pancreatic head and papilla Vateri (46 pts). Out of these, 14 were subdued to successful palliation by duodenobiliar drainage. Nine cases were unsuccessful. Three patients were indicated for percutaneous transhepatical drainage (PTD), one exited during ERCP.

After the evaluation of the general state of patients, as well as their prognoses, the results of screeening methods (USG, CT, ERCP), and the markers, 41 ptients were indicated for palliative surgical treatment. There were 24 men and 17 women in total, aged 45–86 years (average age was 73.8 yrs). The causes of malignant jaundice in this collection are shown in Table 1.

Operations that were performed to this sum (Tab. 2): We added in 18 patients to derivating action on bile tract a gastroenteroanastomosis for existing gastric outlet stenosis and two times splanchnicectomy for conservatively uninfluencable algic syndrome.

Results

Jaundice decreased in 21 patients (51.2 %). The diminished of subjective difficulties took place in 8 patients (19.5 %). The treatment had no effect on 3 patients (7.4 %). Nine patients (21.9 %) exited in 30 days following surgery, out of whom 7 in result of progressive hepatorenal syndrome, 1 due to hemorrhagic shock and 1 due to concomitant symptoms of septic shock. The prognosis depended on the spread of the disease. None of the patients survived longer than 6 months following the surgery.

Discussion

The preciseness of staging of the disease is the crucial moment leading to the selection of the most suitable method of pal-

Department of Surgery, Faculty of Medicine, Comenius University, Hospital Ruzinov, Bratislava

Address for correspondence: M. Hutan, MD, PhD, Dept of Surgery, Hospital Ruzinov, Ruzinovska 6, SK-826 06 Bratislava, Slovakia.
Phone: Fax:

Tab. 1. Causes of malignant jaundice.

Cause	Number
tumor of head of pancreas	20
tumor of papilla Vateri	3
tumor of porta hepatis	6
carcinoma of gallbladder with intrusion into bile duct	10
carcinoma of liver with intrusion into porta	1
infiltration of hepatoduodenal ligamentum with malignant non-Hodgkin lymphoma	1
Total	41

Tab. 2. Palliative operations' derivations.

Procedure	Number
cholecystostomy	3
Kehr drainage with overbridgeing of malignant stenosis	7
choledochojejunoanastomosis	10
cholecystojejunoanastomosis	3
hepaticojejunoanastomosis with Voelcker's drain	6
diahepatic drainage in U shape	1
hepaticojejunoanastomosis on III liver segment	5
hepaticogastroanastomosis on III liver segment	1
explorative laparotomy	5
Total	41

liative treatment of malignant jaundice. The assessment of stage should be based on complex examination. Should the assessment of the stage of the diseases be based only on CT examination, its preciseness rate in only 40 %. Laparotomy provides more detailed information, however it does not eliminate operational risks. According to literature, the diagnostic and therapeutic considerations should be based on the combination of dynamic CT and laparoscopy, thus providing the preciseness rate of 90 % (1).

Endoscopic treatment yields lower morbidity and mortality, and does not strain the patient to great extent. However, it is frequently due to stuffed stents, their dislocation, migration and possible infection. Its use is appropriate in cases of obstruction in the area of distal duct.

The use of percutaneous transhepatical drainage is appropriate mainly in cases of obstructions within the proximal bile duct, however coincides with higher mortality when compared with endoscopic implantations of stents of the same thickness. Self-expansive metallic/wall stents are 15–20 times more expensive than standard polyethylene stents.

Despite the fact that surgical treatment coincides with higher morbidity and mortality, its palliations are of long-term duration without the need of repeated intervention. However, the fact that other palliative procedures (gastroenteroanastomosis, splanchnic ectomy) can be performed should not be omitted.

When selecting the most suitable palliation of malignant jaundice, the following factors are to be considered: 1) patient's overall condition, 2) presumption of patient's survival, 3) technical, personal, and economic factors, 4) effectiveness of procedure, 5) morbidity and mortality of palliative treatment.

References

1. Molinari M, Helton WS, Espat NJ. Palliative strategies for locally advanced unresectable and metastatic pancreatic cancer. Surg Clin N Amer 2001; 81 (3): 651—666.

2. Niederle B. Chirurgie žlučových cest. Praha, Avicenum 1977, 794 p.

3. Černý J et al. Špeciálna chirurgia 2. Martin, Osveta 1992, 585 p.

Received March 20, 2002.
Accepted April 15, 2002.