

"When life gives you a kick, let it kick you forward."

Recently we came across a very interesting article about giraffes. Baby giraffes never go to a business school or office. But they learn a very important lesson much early in life. A lesson that all of us would do well to remember. The birth of a baby giraffe is quite an earthshaking event. The baby falls from its mother's womb, some eight feet above the ground. It shrivels up and lies still, too weak to move. The mother giraffe lovingly lowers her neck to kiss the baby giraffe. And then something incredible happens. She lifts her long leg and kicks the baby giraffe, sending it flying up in the air and tumbling down on the ground. As the baby lies curled up, the mother kicks the baby again and again until the baby giraffe, still trembling and tired, pushes its limbs and for the first time learns to stand on its feet. Happy to see the baby standing on its own feet, the mother giraffe comes over and gives it yet another kick. The baby giraffe falls one more time, but now quickly recovers and stands up. Mama giraffe is delighted. She knows that her baby has learnt an important lesson: ***"Never mind how hard you fall, always remember to pick yourself up and get back on your feet."***

Why does the mother giraffe do this? She knows that lions and leopards love giraffe meat. So unless the baby giraffe quickly learns to stand and run with the pack – it will have no chance of survival. When we fail, when we are down, when people around us kick us, we just give up. We feel lost. But these kicks are the real impetus for us to get out of our comfort zone and to remind us that to progress in our life, we need to learn to get back on our feet. If we study the lives of successful people, we will see a recurring

pattern. Were they always successful in all they did? No. Did success come to them quick and easy? No, We will find that the common streak running through their lives is their ability to stand up every time they fall. The ability of the baby giraffe!

Failures are stepping stones to success. But in reality it becomes very difficult for us to face repeated failures. We may face one or two failures, but when there are setbacks in every walk of life, then we tend to become morose and our morale goes down. We start losing hope and faith in Lord as well.

In the 1920s, Ernest Hemingway learned something about 'bad luck' and getting kicked by life. He was struggling to make his mark as an author when disaster struck. He lost a suitcase containing all his manuscripts - many stories he'd polished to jewel-like perfection - which he'd been planning to publish in a book.

According to Denis Waitley in his book *Empires of the Mind* (published by William Morrow and Company, Inc. in 1995), the devastated Hemingway couldn't conceive of redoing his work. All those months of arduous writing were simply wasted.

He lamented his predicament to friend and poet Ezra Pound who called it a stroke of good fortune! Pound assured Hemingway that when he rewrote the stories, he would



forget the weak parts; only the best material would reappear.

He encouraged the aspiring author to start over with a sense of optimism and confidence. Hemingway did rewrite the stories and eventually became a major figure in American literature.

Don't pray for fewer problems; pray for more skills. Don't ask for smaller challenges; ask for greater wisdom. Don't look for an easy way out; look for the best possible outcome.

"It aint about how hard you hit, it's about how hard you can get hit and keep moving forward. How much you can take and keep moving forward" - Rocky Balboa

**Dr. Harpal Singh Malhotra
Shubham Bhatia**

More people would learn from their mistakes if they weren't so busy denying them.

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Laparoscopic Management of Choledochal Cyst

Laparoscopic total excision of Choledochal cyst with intracorporeal Roux-en-Y hepaticojejunostomy for Choledochal cyst type I in a 28 year old female.

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Abstract

Background:

Choledochal cysts are rare congenital anomalies of the bile ducts. They consist of cystic dilatations of the extrahepatic biliary tree, intrahepatic biliary radicles, or both.

Though their cause is uncertain, these cysts are usually referred for surgical resection because of their association with developing malignancy. In the past, Choledochal cysts were often treated using drainage procedures; however, the optimal treatment used today involves the complete excision of the extrahepatic duct, cholecystectomy, and Roux-en-Y hepaticojejunostomy. We present a case of Type I Choledochal cyst managed laparoscopically.

Case Report:

A 28 year old female presented with complaints of pain abdomen and mild jaundice. She was diagnosed to have Type 1 Choledochal Cyst by gastroenterologist (Dr. Anil Arora & his team) and ERCP / stenting done. Patient was referred for surgical management.

Diagnostic laparoscopy revealed omental and duodenal adhesions in the region of gall bladder and CBD. There was a fusiform dilatation of CBD from ductal confluence till upper border of pancreas. Choledochal cyst was separated off from portal vein and hepatic artery and lifted up. Pre-operatively placed CBD stent removed after opening the cyst. Cyst was excised with cholecystectomy leaving behind a small proximal cuff of cyst

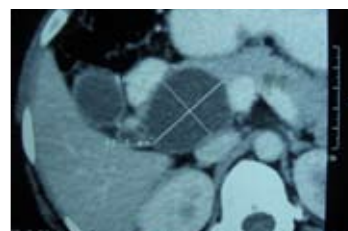
for hepaticojejunostomy. Roux-en-Y loop of jejunum was created and taken in a retrocolic fashion for bilio-enteric anastomosis. Hepaticojejunostomy was created with single layer PDS 4-0 interrupted sutures (intracorporeal suturing). Mesentric defects were closed.

Conclusion:

In summary, we present the feasibility and safety of total laparoscopic management of choledochal cyst. The technique is demonstrated in the video.

Case presentation

A 28 years old female patient presented with a 2 months history of abdominal colic and intermittent fever. On physical examination, she had right upper quadrant tenderness and mild jaundice. Her laboratory values were significant for a total bilirubin of 3.88mg/dL. A CT-scan diagnosed a Choledochal Cyst type Ic measuring 4.5 x 4.8 x 6.0 cm. This was confirmed on magnetic resonance cholangiopancreatography (MRCP). In this image from the MRCP, we see an enlarged fusiform choledochal cyst involving the common bile duct. ERCP & CBD stenting done.



CECT reveals dilated CBD



MRCP: Type 1 Choledochal Cyst

Patient position

The patient is placed in a lithotomy position. The surgeon stands between the patient's legs and the monitor is at the height of the patient's head. The scrub nurse and camera surgeon is at the operator's right and the assistant is at the surgeon's left. A 12mm umbilical trocar is introduced for the 30 degree optic, and two 5mm trocars are placed lateral to the umbilicus, below the umbilical line to be sufficiently away from the operative site. Another 12mm trocar is placed on left side of the patient for stapler.



Calot's triangle dissection and cystic artery division

Dissection of the Calot's triangle and division of the cystic artery is done between 2 clips.

Cystic duct is marked with a clip but not divided to aid in identification later on. The gallbladder will only be removed at the very end of the procedure.

Initial dissection of choledochal cyst

With the abdominal cavity accessed, the gallbladder is grasped and retracted cephalad. We begin by identifying the anatomy of the choledochal cyst, of the accessory biliary duct and of the duodenum. Under mild traction, the peritoneum overlying the cyst is incised. A combination of sharp, blunt and electrocautery dissection is utilized to expose the cyst. The duodenum is mobilized with a Kocher maneuver to ensure complete excision of the choledochal cyst.

Common hepatic duct dissection and division

The dissection leads us to reach the common hepatic duct immediately above the choledochal cyst. Posterior dissection is done to separate the cyst from portal vein and hepatic artery.

Intrapancreatic dissection

Dissection is continued towards the distal portion of the choledochal cyst and the distal extremity of the intra-pancreatic common bile duct is traced using the Harmonic Ace.

Distal intrapancreatic closure of common bile duct

CBD is opened and previously placed stent is removed. Echelon stapler 45 is used to close the distal intrapancreatic section of the common bile duct.

Creation of Roux limb for biliary reconstruction

With the choledochal cyst excised, the ligament of Treitz is identified with the aid of a Babcock forceps and blunt grasper. The bowel is then run in preparation for the Roux-en-Y limb. The Harmonic Ace is utilized to divide the mesentery approximately 40cm distal to the ligament of Treitz. Through the 12mm port, a linear Echelon stapler 45 blue is introduced and the bowel is divided. The distally divided bowel is then run to a length of approximately 60cm to create the Roux limb to be anastomosed to the common bile duct. We then place two stay sutures, which are tied to secure the bowel in a side-to-side fashion. With tension on the stay sutures, enterotomies are then made into the bowel. A stapler is then placed through these enterotomies to create a side-to-side stapled jejunojunction. The enterotomy where the stapler was introduced is closed with a running suture. Constant tension is placed on the suture by the assistant to ensure a tight closure. The knot is then tied intracorporeally to complete the jejunojunction. The Roux limb is then brought retrocolic through a defect created in the transverse mesocolon. We appreciate a good length with no tension in the preparation for the hepaticojejunostomy. An enterotomy is again made in the roux limb with the hook cautery.

Construction of hepaticojejunostomy

The posterior wall of the hepaticojejunostomy is created with 4/0 PDS suture in an interrupted fashion. Similarly, the anterior wall is completed with a series of interrupted 4/0 PDS sutures.

Excision of choledochal cyst

With careful dissection, we had no difficulty dissecting the cyst off the hepatic artery and portal vein.

Completion of cholecystectomy

At the end of the procedure, the cholecystectomy is completed with removal of the gallbladder out of its liver bed.

Closure of mesocolic defect

With the choledochal jejunostomy complete, the defect in the mesocolon is closed to prevent an internal hernia.

Specimen extraction

The entire specimen including all of the accessory and main extra-hepatic bile duct is withdrawn using an extraction bag.

Completion of operation

A 5mm flat drain is placed adjacent to the choledochal jejunostomy.

The patient recovered well and was discharged home on postoperative day 5. She had complete resolution of her symptoms and normalization of her bilirubin levels.



External view during surgery



Gall bladder dissection



Fusiform Dilatation of CBD



Cystic artery being divided



Posterior dissection of choledochal cyst



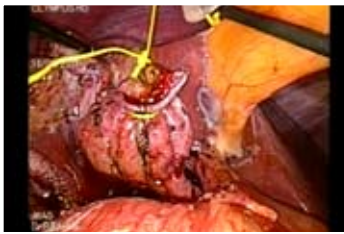
Looping around the cyst with vascular tape



Opening the cyst & removing CBD stent



Dividing lower end of cyst with Echelon 45mm stapler



Choledochal cyst being retracted cranially



Measurement from DJ flexure for Roux-en-Y jejunal limb creation

RNI NO.: DELENG/2001/6114
REGD. NO.: DL(W) 10/2076/2009-11
LICENSED TO POST WITHOUT
PRE-PAYMENT: U(W)-38/2009-11
Posted on 21st / 22nd of every month



Dividing Jejunum 40cm from DJ flexure



End to side Jejunostomy with Echelon 60mm stapler



Closure of Enterotomy



Creation of retrocolic window for roux limb



Roux limb being taken to porta without any tension



Cranial division of Choledochal cyst



Common Hepatic Duct opening seen



Enterotomy made in roux limb



Hepaticojejunostomy created with PDS 4-0, single layer interrupted sutures



Completion of Hepaticojejunostomy



Removal of specimen in Endobag



Closure of mesenteric defect

Mini Gastric Bypass

Live operative workshop

Faculty: Dr. Robert Rutledge, Las Vegas, USA

Friday, September 23, 2011
(9:00 AM onwards)

Organised by Institute of Minimal Access, Metabolic & Bariatric Surgery (iMAS)

Venue: Sir Ganga Ram Hospital, Rajinder Nagar, New Delhi 110060.

For Registration,
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