Original Research Article

Treatmentandoutcomeofcholedochalcysts - ,ourexperienceinSheikhRusselNational Gastroliver Institute and Hospital, Mohakhali Dhaka

ABSTRACT

Objectives: *The aim of the study's goal was to evaluate look at the demographic information, clinical features, surgical methods, postoperative complications after surgery, and outcomes at 6 months for patients with choledochal cysts who were treated at the Sheikh Russel National Gastroliver Institute and Hospital. The goal was to assessseethe outcomes of how well radical cystectomy versus and partial hepatectomy in the treatment of worked for treating choledochal cysts.* ***Methods****: This was a retrospective analysis of 36 patients who had choledochal cysts and were treated with either a total cystectomy (n=30), or partial hepatectomy (n=6).* ***Results:*** *The groups that hadunderwent radical cystectomy and partial hepatectomy had similar age ranges, sex distributions, and types of cysts. The majority of the Most of the cysts were type I (83.3% of the total cystectomy group) and type V (100% of the partial hepatectomy group). Other abnormalities, included: such as gallstones (26.7% vs. 83.3%) and APBDJ (36.7% vs. 16.7%).An increased frequency of post operative There were more pain, jaundice, upper abdominal swelling, and fever episodes was noted in the group thathad a radical cystectomy. Minimal Minimum ofpost operative complicationsafter surgery were seen in both groups. Complications included: These includedsmall bile leakage (16.7% in both), bleeding (3.3% vs. 16.7%), and intestinal obstruction (3.3% vs. 16.7%).At 6 months, the ratesofcomplicationswere similar stillaboutthesame,with hypertrophicscars being themostcommon(30.7%for radical cystectomy and 25% for partial hepatectomy).* ***Cconclusion:*** *The groups that had radical cystectomy and partial hepatectomy had mostly the samewere of similar demographics, cyst types, abnormalities, clinical traits, and complication rates after postsurgery and at 6 months. Both procedures are still good ways to treat choledochal cysts, and this small group doesn't clearly show which is better. To get a better idea of differences in long-term results, bigger studies are needed.*

Keywords:*choledochalcysts,cystectomy,hepatectomy,gallstones, paediatrics,*

Introduction

Choledochal cystsarenaturallyoccurring problemscongenital cystic dilations inofthebiliarysystemwhich may be thatarepresented asextrahepaticand/orintrahepatic biliarytubesgettinglikecysts[1].Butcholedochalcystscanhappentopeopleofanyrace,eventhoughtheyaremorecommon in Asian communities[1]. If the bile system gets blocked, the symptoms can range from having no symptoms at all to having problems like upper abdominal pain, jaundice, pancreatitis, and cholangitis [2]. Even though surgery is the most common treatment choice, there is still disagreement about the best way to do it.

This studyretrospectively examined the clinical characteristics, treatment, and results of patients with choledochal cysts who underwent surgical intervention at a specialized hepatobiliary center. The study aimed to examine demographic data, clinical characteristics at presentation, kindstypes of choledochal cysts, surgical techniques conducted, postoperative complications, and follow-up.Informationfrom36individualswhounderwentsurgeryforcholedochalcystillnessthroughoutover a5-yeartimeframe was gathered and examined [3]. The surgeries conducted were either radical cholecystectomy with Roux-en-Y hepaticojejunostomy or partial hepatectomy. Todani categorization method precisely categories classifiescholedochal cysts according to their location,extent,and form [4].The majorityofinstances featurecysticor fusiform dilatationofthecommonbile duct, knownasTypeIcysts.TypeIIcystsareoutgrowthsresemblingdiverticulathatoccurinthecommonbileduct.TypeIIIcysts, which are often referred to as choledochoceles, are cystic enlargements of the section of the common bile duct that is located withintheduodenum[5].TypeIVcystsareclassifiedintotwo subtypes: IVa,characterisedbythepresenceofseveralcystsin theextrahepaticbileducts,andIVb,whichinvolvesboththeintrahepaticandextrahepaticbileducts.Caroli'sdisease illness,sometimes referred to as Type V cysts, is aredistinguished by the presence of one or more cysts within the biliary ducts of theliver[5].

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Comment [A1]: This needs to be specified as n= (i.e number of patients in the study group)
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Comment [A2]: I don't think the word abnormalities works here because gallstones isn't really an abnormality, its a known co existing pathology - maybe consider something like "associations"
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Comment [A3]: Abbreviation not yet specified - it is not understood what this abbreviations stands for until specified in the text
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Comment [A4]: This is a very very small sample size and limited conclusions can be ascertained from this in terms of statistical significance especially over a span of 5 years
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Studyingcholedochalcystsabouttheirappearance,investigations,therapy,andoutcomesmightenhanceourunderstandingof the condition in our community [6]. We might also use it to compare the outcomes and potential issues of various surgical methods. Thismightaid indevelopinganeffective managementregimenfor theseindividuals.Theconstraint wasthelimited sample size and brief follow-up period.This studyoffers preliminaryinsights on choledochal cyst illness inour environment.

Methodology

The studywasa retrospective analysisdone atthe DepartmentofHepatobiliaryPancreatic Surgeryat Sheikh Russel National GastroliverInstituteandHospitalinDhaka,Bangladesh.The study time frame spanned ~~Studytime:~~1 January~~1,~~2022~~,~~to1 January~~1,~~2024. Inclusion criteria included: Patientsyoungerthan 16yearsold,thosewhodid not have coexisting ~~don'thave~~acutepancreatitis,~~or~~cholangitis or pulmonary disease,andthosewhohave not undergone any major cardiac surgeries. ~~don'thaveanymajorheartorlungproblems were allowed to participate.~~ The medical and surgical records of the 36 patients were assessed. ~~peoplewho had surgery for choledochal cysts between January 2022 and January 2024 were used to gather this information.~~ Radical cyst removal with Roux-en-Y hepaticojejunostomy or partial hepatectomywasthesurgeriesythat~~was~~were done.Aftersurgery,thepatientswere~~watched~~followed for6months.Thedatathatwasgathered included demographic information, clinical characteristics, diagnostic tests, surgeries and ~~,~~postoperative complications ~~problems that happened after surgery, and more tracking.~~ SPSS version 23 was used to ~~look at~~assess the data. For numerical data, the mean and standard deviation were ~~shown~~calculated .Forcategoricaldata,thefrequencyandratioswereused.A p value of less than 0.05 indicated statistical significance. ~~Statisticssaidthatsomethingwasimportantif~~thePvaluewas less than 0.05.

Results

By looking at the information in the tables, we can see a number of important facts about how choledochal cysts are treated and how well they do at the Sheikh Russel National Gastroliver Institute and Hospital in Mohakhali, Dhaka.

The patients' ages, genders, and other characteristics are shown in Table 1. Thirty of the patients (30 out of 36) had a radical cystectomy with Roux-en-Y hepaticojejunostomy. The other six patients had a partial hepatectomy. There was a slight bias towardguysinbothtreatmentgroups,butthenumberofwomenand menwasaboutequal.Peopleinthestudywereanywhere from 1 to 16 years old, with a mean age of about 9 years in both groups.

Table1:Distributionofthepatientsaccordingdemographic(N=36)

Variable	**Radical Cystectomy with Roux-en Y-Hepaticojejunostomy (N=30)**	**Partial Heptectomy(N=6)**	~~**P value**~~
Gender	n (%)	n (%)	
Male	18 (60.0)	3 (50.0)	~~0.0194~~
Female	12 (40.0)	3 (50.0)	
Agegroup			
1-5 yrs	8 (26.7)	2 (33.3)	
6-10yrs	9 (30.0)	1 (16.7)	~~0.0001~~
11-16yrs	13 (43.3)	3 (50.0)	
AgeyrsMean± S	9.58±4.62	9.17±5.19	~~0.0001~~

Comment [A5]: Good that the authors have recognised the limitations of the study

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Comment [A6]: Inclusion and exclusion criteria for the study needs to be very clearly documented so there is no confusion

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Comment [A7]: This is simply a summary table to introduce the statistical data giving the ages , means for each procedure. A p value is not calculated for this as we are not looking for statistical significance in this instance - as the table heading states it is purely to show distribution there is no comparison

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Comment [A8]: According to the way this is worded - it implies n = % which is not the case. N is a numerical value which is then subsequently depicted as a percentage

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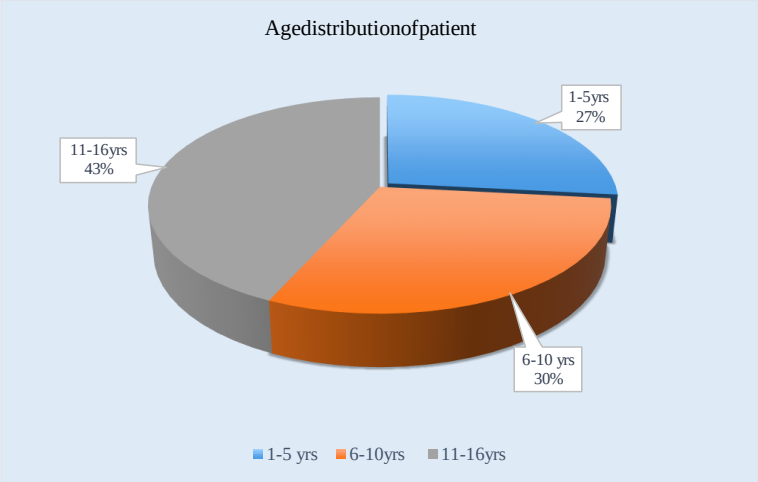
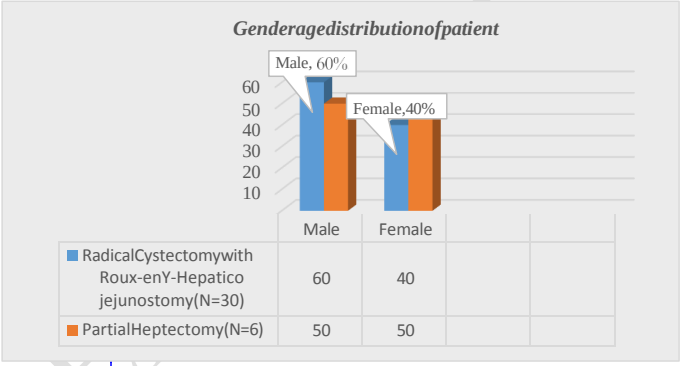


FigureI:Piechartshowedagewisepatientsdistribution(N=36)



FigureII:Berchartshowedgenderwisedistribution(N=36)

Table2:Distributionofthepatientsaccordingtodifferentanomaly(N=36)

Variable	Radical Cystectomy with Roux-en Y-Hepaticojejunostomy (N=30)	PartialHeptectomy (N=6)	P value
Type	**n (%)**	**n (%)**	
I	25 (83.3)	0 (0.0)	0.0070
II	3 (10.0)	0 (0.0)	
III	0 (0.0)	0 (0.0)	
IV	2 (6.7)	0 (0.0)	
V	0 (0.0)	6 (100.0)	
Associated gallstone			
Yes	8 (26.7)	5 (83.3)	0.0001
No	22 (73.3)	1 (16.7)	

Comment [A9]: Needs rewording

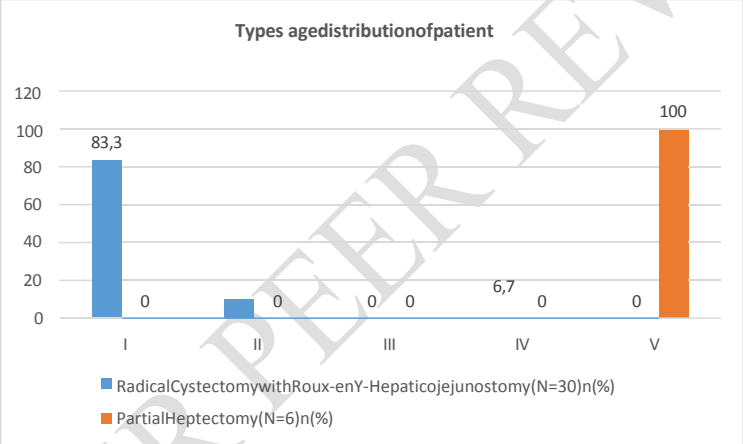
Comment [A10]: This table is mislabeled on x and y axis - under male and female it does not indicate this is a percentage number - only in the white blurb box (which is not a formal axis delineation)

Comment [A11]: There is no mention as to how this diagnosis was made ? CT , US ? This is a radiological or intra operative diagnosis

Comment [A13]: Comment as above for P value this is not calculating statistical significance - please read up about where this is to be used appropriately to test a null hypothesis

Comment [A12]: Comment as above for n and %

APBDJ			
Yes	11 (36.7)	1(16.7)	0.357
No	19 (63.3)	5(83.3)	
Otheran omaly			
Hydrocephalus	2 (6.7)	2 (33.3)	0.0001
No	28 (93.3)	4 (66.7)	
Associated portalhyper tension			
Yes	8 (26.7)	3 (50.0)	0.0001
No	22 (73.3)	3 (50.0)	
Post-operative Hospital stay (Days)**Mean± SD**	11.83±2.10	10.17±1.17	0.0001



FigureIII:columnchartshowedTypesagewisedistribution(N=36)

Thetypesofcholedochalcysts,thediseasestheycancause,andthelengthofhospitalstayaftersurgeryareallshowninTable 2.Notably, mostofthepatientswhohadradicalcystectomyhadTypeIcholedochalcysts(83.3%),whilethepatientswhohad partialhepatectomyhadTypeV(100%)cysts.Patientswhoweregoingtohaveapartialhepatectomyweremorelikelytohave gallstonesbutanabnormalpancreaticbiliaryductjunction(APBDJ)were less.Thegroupthathadthepartialhepatectomyalsohadmore cases of other problems that were linked to it, like hydrocephalus and portal hypertension. The average length of stay in the hospital after surgerywas a little longer for the radical cystectomygroup (11.83 ± 2.10 days) than for the partial hepatectomy group (10.17 ± 1.17 days).

Comment [A14]: Abbreviation not yet defined in text

Comment [A15]: What does this mean ? Why is hydrocephalus relevant to HBP ? And if so, why was a CTB then done for each patient ?

Comment [A16]: How was portal HPT diagnosed? CT or US - there is no mention of the relevance of portal hypertension in the literature review relating to choledochal cysts and surgery

Comment [A17]: Table labelled incorrectly

Comment [A18]: Again, how was this dx made?

Comment [A19]: Abbreviation defined for the first time in text here, but it has been used twice already - please look at the journal specifications for abbreviations

Comment [A20]: Again, what is the revlencae of intracranial hydrocephalus relating to choledochal cysts.

Again, how was the dx of portal hypertension dx and was this part of an inclusion or exclusion criteria?

Table3:DistributionofthepatientsaccordingClinicalfeatures(N=36)

Features	Radical Cystectomy with Roux-en Y-Hepatico jejunostomy(N=30)	Partial Heptectomy (N=6)
	n (%)	n (%)
Pain	26(86.7)	2 (33.3)
Jaundice	25(83.3)	2 (33.3)
Abdominalmass	22(73.3)	3 (50.0)
Recurrentepisodesoffever	22(73.3)	4 (66.7)
PaleStool	5 (16.7)	2 (33.3)
Generalizeditching	3 (10.0)	1 (16.7)
Vomiting	8 (26.7)	2 (33.3)
Non-specific	5 (16.7)	1 (16.7)

The clinical features of the cases are shown in Table 3. In both groups, the most common first signs were pain, jaundice, an abdominallump,andfeversthatcameandwent.Butthesesignshappenedmoreoftenin thegroupthathadaradicalcystectomy than in the group that had a partial hepatectomy. In Table 4, you can see a list of the problems that patients had after surgery. Postoperative complications were more common in the radical cystectomy group, with excess postoperative pain (56.7%), minor bile leakage (16.7%), and minor wound infection (10%) being the most frequent. In the partial hepatectomy group, excess postoperative pain (50%), postoperative bleeding (16.7%), and persistent vomiting (16.7%) were the most common complications.

Comment [A21]: Common first signs of post operative complications?

Comment [A22]: What is an abdominal lump? Is it implying a surgical site hernia?

Comment [A23]: Fever is by definition intermittent

Table4:DistributionofthepatientsaccordingPost-operativecomplications(N=36)

Comment [A24]: The table listing clinical features above are also post operative complications - why has this been separated?

Complications	RadicalCystectomywith Roux-en Y-Hepaticojejunostomy (N=30)	Partial Heptectomy(N=6)
	n (%)	n (%)
AcutePostoperativepain	17 (56.7)	3 (50.0)
Minorwoundinfection	3 (10.0)	1 (16.7)
Post-operativeBleeding	1 (3.3)	1 (16.7)
Minorbileleakage	5 (16.7)	1 (16.7)
Nill	1 (3.3)	0 (0.0)
Persistantvomiting	2 (6.7)	1 (16.7)

Table5:Distributionofthepatientsaccording6months'follow-upcomplications(N=17)

Follow-upcomplications	RadicalCystectomywith Roux-en Y-Hepatico jejunostomy(N=13)	Partial Heptectomy (N=4)	P value
	n (%)	n (%)	
Scarpain	1 (7.7)	2 (50.0)	0.379
Hypertrophicscar	4 (30.7)	1 (25.0)	
Abdominalmass	1 (7.7)	0 (0.0)	
Persistentfever	1 (7.7)	0 (0.0)	
Jaundice	1 (7.7)	0 (0.0)	
Ascites	1 (7.7)	0 (0.0)	
Hernia	1 (7.7)	0 (0.0)	
Uglyscar	3 (23.1)	1 (25.0)	

Comment [A25]: What is classified as an "ugly scar" how is this different from hypertrophic scar? This is not a standardised surgical term

Table 5 shows a summary of the problems that were seen in 17 of the 36 patients who were followed up after 6 months. The most common side effects in bothtreatment groups were problems with scars, like pain and scars getting bigger. The radical

cystectomygrouphadotherproblems,likeanabdominallump,feverthatwouldn'tgoaway,jaundice,ascites,andahernia,but the partial hepatectomy group didn't.

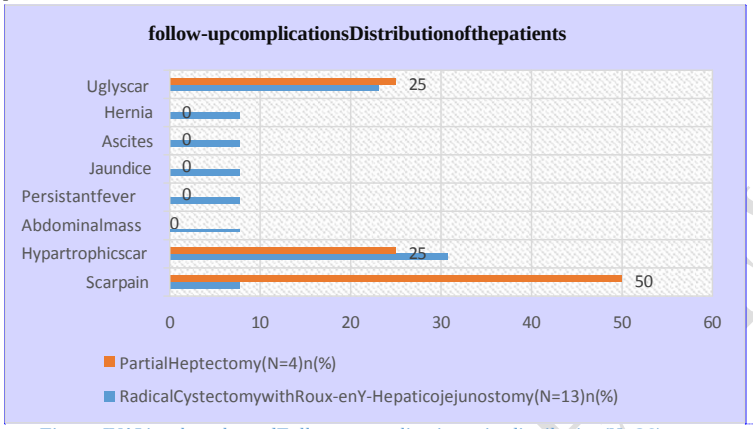


Figure:IVALinechartshowedFollowupcomplicationswisedistribution(N=36)

Discussion

Theresultsofourstudyindicatedagreaterproportionofmalesincomparisontofemales, withamale-to-femaleratioof1.2:0.8, whichalignswithfindingsfrompreviousresearch conductedin IndiaandAsia[7]. The mean ageof onsetinourstudywas 9.58 years, which was consistent with the results of earlier studies. The primary symptoms documented in the literature were abdominal pain, icterus, and a palpable mass in the abdomen. Radical cystectomy with Roux-en-Y hepaticojejunostomy or partialhepatectomywaschosenforsurgery[7].Thisisinline with whatother studieshave found to beusuallygood practice. The best way to treat choledochal cysts is to cut out the whole extrahepatic bile tree [8]. Either a major cystectomy or liver resection can be used to do this. It works best in the long run and makes it less likely that the cyst will turn into cancer. This study'scholedochalcystsshowedupwithstomachpain,redness,alumpthatcouldbefeltinthestomach,andfeversthatcame andwent.Thisissimilartowhatotherstudieshavefound.Themostcommonsignsofcholedochalcystsinkidswereabdominal pain, jaundice, and a lump that could be felt in the belly [9]. The postoperative complications observed in this study, such as excess postoperative pain, minor bile leakage, wound infection, and postoperative bleeding, are commonly reported in the study.Theseareproblemsthathavebeen studied before. After choledochal cyst removal, problems like bile leakage, wound infections, and collections in the belly happened quiteoften(about20%ofthetime)[10]. Thisissimilarto whatotherstudieswithskilledsurgicalteamshavefound: theresultsweremostlygood.Similarproblemswithscars,anabdominallump,feversthatwouldn'tgoaway,jaundice,ascites, and ahernia wereseeninthis studyafter 6 months.Theseproblemshavealsobeenseenin other long-termfollow-up studies. Whencholedochalcystwastakenout,itcouldleadtolong-termissueslikecholedochitis,pancreatitis,andbilestrictures[11]. This could show up as fevers, redness, and a lump in the abdomen [12]. An incisional hernia was more likely to happen in peoplewho had opensurgeryto removeacholedochal cyst[13].~~Thisislike what wasseenasaproblemwithfollowing up in this study.~~ Comparative studies have also shown how important it is to carefully check out the patient before surgery, make surethesurgerygoesasplanned,andbeverycarefulduringthesurgerytogetthebestresultsandavoidproblems.talkedabout how important it is to use imaging tests before surgery, such as magnetic resonance cholangiopancreatography (MRCP), to find out whatkindofcholedochalcystitisandiftherearеanyother issues[14].Thisinformationcanhelpthedoctorplanthe surgeryand makeitgobetter.Overall,theresultsofthisstudyattheSheikhRusselNationalGastroliverInstituteandHospital in Mohakhali, Dhaka, are mostly in line with what other research has said about how to treat choledochal cysts and how well they do. The study shows how important it is to do a thorough evaluation before surgery, plan the surgery correctly, and be verycarefulduringthesurgery.Theseareallveryimportantforgettingthebestresultsandavoidingproblemswhenmanaging this complicated disease.

Comment [A26]: Already delineated in table above - does not need repeating and discussed in text

Comment [A27]: This will depend on intra or extra hepatic or involvement of both

Comment [A28]: This is already discussed above in the types of procedueres

Comment [A29]: Which literature documents this please ?

Comment [A30]: We cannot use informal terms like this in a formal academic journal

Comment [A31]: This is repeated twice in the sentences above this

Comment [A32]: Bleeding where? Subcutaneously ?

Comment [A33]: Again, formal English is needed in an academic setting

Comment [A34]: Results for what were mostly good?

Comment [A35]: Already mentioned 3 times above in consecutive sentences, excessive repetition

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Comment [A36]: Again, not appropriate for an academic journal

Comment [A37]: This has not been discussed anywhere in the study of how a dx was made? CT, US, MRCP, ErCP?

Comment [A38]: The surgical component is not discussed no the aim of this study - why is this being mentioned but then not discussed if the author wishes to focus on this aspect?

Conclusion

The Sheikh Russel National Gastroliver Institute and Hospital in Mohakhali, Dhaka, sent us data that we used to learn a lot abouthowtotreatcholedochalcystsandhowwelltheywork.WhetheratotalcystectomywithRoux-en-Yhepaticojejunostomy or apartialhepatectomyis used for surgerydependsonthe type ofcholedochal cystand anyother conditions thatare present. Complicationsaftersurgerywerelinkedtobothsurgicalmethods.Themostcommonproblemwastoomuchpainaftersurgery. Majorproblemsdidhappen,buttheywerenotverycommon.Thissuggeststhatthesurgicalmethodsused weregenerallysafe and efficient. After 6 months, the follow-up data showed that both treatment groups had problems with their scars. However, only the radical cystectomy group had problems with an abdominal mass, prolonged fever, jaundice, ascites, and a hernia. Overall, the study shows how important it is to carefully evaluate the patient before surgery, plan the surgery correctly based onthetypeofcholedochalcystandanyotherconditionsthatmaybepresent,andbeverycarefulduringsurgeryinordertoget the best results and avoid problems when treating choledochal cysts.

Comment [A39]: How was this assessed? And what is too much pain ?

Comment [A40]: This claim cannot be made as it is Multidisciplinary according to the level of expertise of the surgeon, anaethestist etc

Comment [A41]: The conclusion is simply a repeat of the discussion - it need to show that this study was relevant and justified, not just rehash what has been said throughout the paper

Reference

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