

## Extended Abstract

Endovascular thrombectomy -  
Undergoing procedural sedation  
vs general anesthesia in acute  
stroke patients: A systematic  
review of the literature and  
single- centre retrospective study

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**Abstract**

**Importance:** Better haemodynamic control for patients with acute ischaemic stroke is related to improved neurological outcomes. Thus far there's not sufficient evidence on whether receiving anaesthesia or procedural sedation during thrombectomy allows for better haemodynamic control and if this incorporates a subsequent impact on early neurological improvement. **Objective:** To assess whether procedural sedation is superior to general anaesthesia for haemodynamic control and early neurological improvement among patients receiving stroke thrombectomy. **Design, Setting, and Participants:** This paper will have a two part design. First a literature review and meta-analysis are done to analyse the prevailing evidence. Secondly a retrospective study of 150 patients with acute ischemia in who received thrombectomy in CCAD is going to be completed. **Outcomes:** the first outcome measures are direct mean blood pressure during thrombectomy and NIHSS after 24 hours, at discharge and after 3 months. Secondary outcome measures are going to be direct systolic pressure, episodes of desaturation, mortality, length of hospital stay, modified rankin scale at discharge and at 3 months, and complications intraoperatively and within the hospital room. **Conclusion:** The aims of this study are to retrospectively clarify whether anesthesia or procedural sedation give better haemodynamic control during thrombectomy and if this can be related to better early neurological outcomes.

Aislinn Killian completed her bachelor of surgery in Royal College of Surgeons Ireland in 2017. Killian has experience within the field of General Surgery, Psychiatry, medical specialty, and Gastroenterology. Currently Aislinn is functioning on a scientific review and retrospective study on data from Cleveland Clinic national capital, UAE.

The congenital absence of the gallbladder within the absence of biliary atresia is extremely rare, world literature recognizing only 413 cases. The aim of this study is to clarify the diagnostic and therapeutic approach of this rare condition.

There were retrospectively analysed the primary 2 cases of gallbladder agenesis admitted and surgically approached within the Emergency Hospital, Bucharest.

The first case (woman, 23 years old) had typically biliary complaints at admission, shrunken gallbladder and lithiasis on ultrasound. There was a laparoscopic approach but we didn't find any gallbladder. After a non-therapeutic laparoscopy the biliary symptoms disappeared. Within the second case (woman, 52 years old) the admission was for upper abdominal quadrant collective pain and therefore the Trans parietal abdominal ultrasound showed chronic cholecystitis. Common bile duct dilatation was revealed during laparoscopy. After conversion to laparotomy there was performed intraoperative cholangiography, but no other biliary pathology was revealed. The initial complaints also disappeared after surgery.

We find the laparoscopic approach a good method for the diagnosis of gallbladder agenesis. Postoperative resonance Cholangiopancreatography represents a really useful imagistic tool to rule out an intrahepatic gallbladder.

Biliary tract injuries (BTI) represent the foremost serious and potentially life-threatening complication of cholecystectomy. During open cholecystectomies (OC), the prevalence of canal injuries has been estimated at only 0.1-0.2%. We report 3 cases of BTI during lap choly (LC). **CASE 1:** Ascalesi Hospital, Naples 2003-2007, 875 LC (BTI 0, 11%). During the dissection of triangle of Calot a partial resection of biliary common duct was made. Immediately the lesion was evident and sheltered in laparoscopy, suturing with a spin reabsorbable, without biliar drainage. The post-operative outcome was good, without alteration of the some parameters, and therefore the patient was discharged after three days. At the last follow-up (January 2006) the cholangiography didn't show stricture or leakage. **CASE 2:** General and Laparoscopic Surgical Unit San Giovanni di Dio Hospital Frattamaggiore 2004-2007, 720 LC (BTI 0, 13%). Patient plagued by cholecystitis with gallstones. The patient failed to present jaundice, but abdominal pain, leucocytosis, fever and US evidence of parietal gallbladder inflammation. LC was performed after 36 h; during operation, common biliar duct was misidentified for subverted anatomy caused by inflammation. The common duct was clipped, and therefore the patient presented jaundice after three days after operation. The cholangiography was performed showing the stop. Therefore a reoperation was needed and laparotomic Roux-en-Y hepaticojejunostomy was performed. **CASE 3:** Dpt of Emergency Surgery, Second University of Naples 2000-2007, LC 520 (BTI 0, 19%). Patient suffering from over 20 years symptomatic cholelithiasis, with only obesity risk factor; she underwent lap choly and sudden bleeding of the arteria cystic, poor vision and possibly the long history of symptoms, producing a flogistic alteration of the anatomy, caused a misidentification of the cystic duct and also the common channel with complete or lateral clipping of the common

## Extended Abstract

canal. The error was unrecognized intra-operatively but after progressive jaundice the postoperative cholangiography showed a virtually complete stop by two clips. Roux-en-Y hepaticojejunostomy with intraoperative cholangiography control was performed.

The most common explanation for BTI is that the failure to acknowledge the anatomy of constellation of Calot. This can be attributed to factors inherent to the laparoscopic approach, to inadequate training of the surgeon and to local anatomical risk factors. The laparoscopic "learning curve" of the surgeon is that the most significant factor of bile ducts injury. But also local anatomical risk factors are important like acute cholecystitis, severe chronic scarring of the gallbladder and bleeding or excessive fat within the hepatic hilum. These local risk factors seem to be present in 15% to 35% of BTI. Abnormal biliary anatomy, like a brief cystic duct or a cystic duct stepping into the correct canal also may increase the incidence of BTI. Schematic representation of the common mechanisms of BTI during LC are: misidentification of the cystic duct and therefore the common biliary duct, lateral clipping of the common biliary duct, traumatic avulsion the cystic duct junction, diathermic injury of common biliary duct during dissection of the Calot triangle or during the cholecystectomy, injury of anomalous right duct.

Conversion to laparotomy, in difficult cases involving inflammatory changes, aberrant anatomy or excessive bleeding, isn't to be considered as a failure but rather pretty much as good surgical decision so as to confirm the patient's safety.