

Preface



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Guest Editor

In 1981, the *Surgical Clinics of North America* published an issue entitled “Biliary Tract Disease” [1]. This predated any of our attempts at laparoscopic biliary surgery and was state-of-the-art. In 1994, the *Clinics* published “Biliary Tract Injuries Revisited,” straddling the era of “all open” biliary surgery and emerging laparoscopic surgery [2]. This was a trying time for practicing surgeons to learn new techniques, and exciting for residents in training who were becoming competent in the new technology. The experience with referral centers, such as the Lahey Clinic, was a five-fold increase in biliary injuries referred from laparoscopic procedures. Since the introduction of laparoscopic cholecystectomy by Mouret in 1987, an entire generation has grown up with the expectation that biliary surgery is predominantly a minimally invasive procedure. Four “generations” of surgical residents training for 5 years have witnessed this evolution. However, evolution has come with a price. Since Deziel [3] reported a national average of 0.6% common duct injuries, (about a five-fold increase) with laparoscopic cholecystectomy in 1993, this most dreaded biliary complication has never returned to pre-laparoscopic levels.

Surgeons in training now receive fewer opportunities for open operations in the right upper quadrant. Graduating chief residents performed an average of only one open common bile duct exploration in the ACGME logs of 2007 [4]. The fears expressed by Rossi and Pitt [2] that we are turning out fewer residents with the skills necessary for complex biliary surgery or open conversion of laparoscopic cases have not been resolved. We cannot reverse the progression of laparoscopic surgery, but we can strive to train our

residents in the principles of safe laparoscopy and provide them with the knowledge and skills to perform open surgery when necessary.

This issue of the *Surgical Clinics of North America* will try to add on to the traditions of biliary surgery set forth in previous issues. We have learned much about the mechanisms and prevention of laparoscopic bile duct injuries in the last 20 years, and a review of pertinent anatomy and operative techniques will be presented. Diagnosis, palliation, and surgical management of injuries and pathology of the biliary tract have advanced logarithmically. Radiologic techniques are emerging that provide three-dimensional reconstructions of complex biliary anatomy. Endoscopic imaging and treatment options are evolving as rapidly as laparoscopic instrumentation. All of these new technologies are leading to safer, more effective management of proximal and distal biliary malignancy, biliary reconstruction, and preoperative planning for all biliary surgery. We hope that this issue will prove a useful tool both for surgeons just beginning their practice and more senior surgeons whose careers (sometimes anxiously) have bridged the eras of open and laparoscopic surgery.

I wish to thank Dr. Ronald Martin, Consulting Editor, for offering me this opportunity to contribute to the *Surgical Clinics of North America*. I would also like to acknowledge the mentorship of Drs. John Braasch and Ricardo Rossi at the Lahey Clinic, both of whom have taught generations of surgeons to tread cautiously about the right upper quadrant. Finally, I would like to thank our editor, Catherine Bewick, at Elsevier for her invaluable assistance in making this issue come to fruition.

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