

A preliminary note on laparoscopic surgery.

Yany Shayann*

Department of Surgery, Jichi Medical University, Saitama, Japan

Abstract

Laparoscopic cholecystectomy's rapid uptake and popularity have never before been seen in the annals of modern surgery. This has led to attempts to replace open surgical techniques with therapeutic and diagnostic laparoscopy in practically every area of surgery. The list goes on and on. As reports from controlled studies and long-term follow-up results are needed, it will take some time to assess the merits and safety of many of these operations. Many other operations, like as hernia repair, radical resection of intestine for cancer, etc., may fail to do so as the initial enthusiasm wanes. This is true even though certain techniques, such as appendectomy and gall bladder surgery, will demonstrate their many fold advantages over open surgery.

Keywords: Laparoscopic surgery, Gall bladder surgery, Opens surgery.

Introduction

The advent of diagnostic laparoscopy in the 1960s led to the creation of laparoscopic surgery. Beginning in the 1980s, the invention of laparoscopic surgery transformed it from a diagnostic to a surgical operation and since then, it has been a widely used method for a variety of purposes. Many organ systems now use this method as the gold standard, with the reproductive (gynaecological) and digestive systems being among of the most popular. Laparoscopic surgery is now safe and practicable in a variety of medical specialties thanks to significant advancements in surgical education, as well as in surgical tools, imaging technology and surgical procedures [1].

For many years, gynaecologists have used laparoscopy to assess pelvic disease and carry out simple procedures like tube ligation. But until the successful completion of the laparoscopic cholecystectomy, the majority of general surgeons did not recognise its worth. The treatment of cholelithiasis has been revolutionised by the following enthusiasm and widespread acceptance of this operation with its benefits of little to no patient discomfort, a brief hospital stay and great cosmetic results [2].

Faster recovery times, shorter hospital stays, reduced postoperative discomfort, earlier return to work and resume of normal daily activities, as well as cosmetic advantages, are some of laparoscopy's main advantages over open surgery. Today, laparoscopy is widely regarded as the gold standard of care for treating appendicitis and cholecystitis. Even colorectal surgery has adopted laparoscopy with positive outcomes [3]. The use of laparoscopy in procedures involving totally intracorporeal anastomoses has been made possible by technological advancements in this surgical sector, the development of contemporary techniques, and the acquisition

of specialised laparoscopic skills. Single-incision laparoscopic surgery and natural orifice trans-luminal endoscopic surgery represent additional advancements in laparoscopy [4].

Despite this, laparoscopy for urgent surgery is still regarded as difficult and is typically not advised due to the lack of sufficient experience in this field. Additionally cited as a factor are the operational challenges presented by diffuse adhesions, extensive purulent collections and diffuse peritonitis. However, it is obvious that laparoscopy may be advantageous for both diagnosis and treatment. Major benefits can be shown, for instance, in cases of diffuse peritonitis caused by perforated peptic ulcers, where laparoscopy enables the diagnosis to be confirmed, the location of the ulcer to be identified and a laparoscopic repair with successful peritoneal washout [5].

Conclusion

As an activity, surgery is a dynamic, developing field. Laparoscopy is a direct result of advancements in surgery. Laparoscopy has transformed emergency surgery's approach to treating acute cholecystitis and is now accepted as the gold standard of care for treating acute appendicitis. Laparoscopy has also been used to treat a variety of other urgent disorders, suggesting its potential to affect a variety of other conditions currently managed by open surgery.

References

1. Di Saverio S, Bassi M, Smerieri N, et al. Diagnosis and treatment of perforated or bleeding peptic ulcers: 2013 WSES position paper. *World J Emerg Surg.* 2014;9(1):1-5.
2. McBURNEY CH. The incision made in the abdominal wall in cases of appendicitis, with a description of a new method of operating. *Ann Surg.* 1894;20(1):38.

*Correspondence to: Yany Shayann, Department of Surgery, Saitama Medical Center, Jichi Medical University, Saitama, Japan, E-mail: yany@shayann21.jp

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3. Kehagias I, Karamanakos SN, Panagiotopoulos S, et al. Laparoscopic versus open appendectomy: which way to go? *World J Gastroenterol: WJG*. 2008;14(31):4909.
4. Cirocchi R, Abraha I, Farinella E, et al. Laparoscopic versus open surgery in small bowel obstruction. *Cochrane Database Syst Rev*. 2010(2).
5. Shahedi K, Fuller G, Bolus R, et al. Long-term risk of acute diverticulitis among patients with incidental diverticulosis found during colonoscopy. *Clin Gastroenterol Hepatol*. 2013;11(12):1609-13.