

# Total versus conventional laparoscopic cyst excision and Roux-en-Y hepaticojejunostomy in children with choledochal cysts: a case-control study

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## Research article

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# Abstract

**Background :** To compare the efficacy of total and conventional laparoscopic hepaticojejunostomy (TLH and CLH) in children with choledochal cysts (CDCs).

**Methods:** Patients undergoing TLH and CLH between August 2017 and December 2018 were retrospectively analyzed. Intraoperative blood loss, time for jejunum-co-jejunum anastomosis, time to oral intake, postoperative hospital stay, hospitalization expenses, postoperative complications were compared.

**Results:** All 55 patients (TLH=30, CLH=25) were successfully treated without conversion to open surgery. In the TLH and CLH groups, the time to oral intake was  $3.57\pm 0.19$  d and  $4.56\pm 0.27$  d, respectively ( $t = 3.07$ ,  $P < 0.01$ ), the postoperative hospital stay was  $5.50\pm 0.28$  d and  $7.00\pm 0.74$  d ( $t = 2.03$ ,  $P < 0.05$ ), the hospitalization expenses were CNY  $40085\pm 2447$  and CNY  $26084\pm 2776$  ( $t = 3.79$ ,  $P < 0.001$ ). There were no significant differences in intraoperative blood loss ( $9.57\pm 3.28$  ml vs  $8.2\pm 1.13$  ml,  $t = 0.37$ ,  $P = 0.72$ ) and time for jejunum-co-jejunum anastomosis ( $80.5\pm 2.46$  min vs  $75.00\pm 2.04$  min,  $t = 1.68$ ,  $P = 0.10$ ). The median follow-up periods of TLH and CLH group were 17 and 16 months respectively. Overall complication rates were comparable between two groups (10% vs 8%,  $\chi^2 = 0.07$ ,  $P = 0.79$ ).

**Conclusions:** TLH in children with CDCs has the advantages of rapid gastrointestinal functional recovery and short hospitalization. However, hospitalization is relatively expensive.

## 1. Background

Choledochal cysts (CDCs) are a rare congenital biliary malformation. The incidence of CDCs in western countries ranges from 1/50,000 to 1/200,000, while that in Japan is approximately 1/13,000, with a male-to-female ratio of 1:4 [1-3]. Total cyst excision with Roux-en-Y hepaticojunctionostomy has become the standard procedure [4]. In 1995, Farello et al. [5] reported for the first time the laparoscopic-assisted treatment of CDCs. Currently, the laparoscopic treatment of CDCs has been widely accepted by surgeons and children for its advantages of a small incision, less trauma, less pain and quick recovery [6,7]. The gradual improvement of laparoscopic instruments and surgical techniques has made it possible to treat CDCs in children by total laparoscopy. However, considering the limited space of the abdominal cavity, the difficulty of the operation and the high cost of hospitalization, it has not been widely performed [8]. From August 2017 to December 2018, we compared the efficacy of total laparoscopic hepaticojejunostomy (TLH) and conventional laparoscopic hepaticojejunostomy (CLH) in children with CDCs.

## 2. Methods

We retrospectively analyzed the data of 30 children who underwent TLH and 25 children who underwent CLH from August 2017 to December 2018. All patients were evaluated by ultrasonography, computed tomography (CT), or magnetic resonance cholangiopancreatography (MRCP) before the operation.

Considering the so limited abdominal cavity space of a child, we set the inclusion criteria for the TLH group as: children of >1 year old with CDCs. The exclusion criteria were: (a) children of  $\leq 1$  year old; (b) with history of upper abdominal surgery; (c) encountered uncontrolled acute cholangitis; (d) suffered cardiovascular or other diseases that cannot tolerate total laparoscopic surgery; (e) parents did not accept total laparoscopic surgery.

Patients of no following preconditions were included in CLH group: (a) upper abdominal surgery history; (b) uncontrolled acute cholangitis; (c) cardiovascular or other diseases that cannot tolerate laparoscopic surgery; (d) parents did not accept laparoscopic surgery. Ethical approval from the Institutional Review Board of Guangzhou Women and Children's Medical Center and written parental consent were obtained. The research was conducted in compliance with the World Medical Association Declaration of Helsinki.

## 2.1 Operative Techniques

### 2.1.1 Total laparoscopic CDC excision and Roux-en-Y hepaticojejunostomy

The patient was placed in a supine position. A carbon dioxide pneumoperitoneum was established at 6-12 mmHg (age  $\leq 1$  year: 6-8 mmHg; 1-3 years: 8-10 mmHg; and >3 years: 10-12 mmHg [6]). A 5-mm 30° laparoscope was introduced via a 5-mm port through an intraumbilical incision. Under laparoscopic guidance, the second and third ports were established below the costal margin at the right and left upper quadrants. The fourth port was established 4-5 cm below the second port.

A 2-0 hitch stitch was passed through the anterior abdominal wall and falciform ligamentum to expose the hepatic hilum. Cyst dissection was started anteriorly using a monopolar electrocautery instrument and continued distally to the posterior duodenal wall (Fig. A). When a rim of the lower portion of the cyst was held cephalad by the operator, the duodenum was pulled caudad by the assistant, and the cleavage between the cyst and the pancreas could be clearly identified. Then, the anterior wall of the cyst was opened transversely to examine the duct system directly for stone debris and ductal stenosis. Under the magnified view of the laparoscope, stone debris and ductal stenosis were recognized easily. When stones and debris were found, the ducts were irrigated with saline to clear out this material. When stenosis was identified, ductoplasty was performed laparoscopically. The full thickness of the cyst was dissected as closely as possible to the wall using the cautery instrument until the narrow portion distal to the cyst appeared. The narrow portion was ligated securely with a 4-0 nonabsorbable suture and transected (Fig. B). Subsequently, the distal part of the cyst was dissected closely to the posterior wall of the cyst (Fig. C) to avoid injury to the portal vein. The cyst was completely excised close to the hepatic hilum at the junction between the normal common hepatic duct and dilated cystic wall.

The ligament of Treitz was identified under laparoscopy, and the proximal jejunum 20 cm distal to the ligament was cut off using an Endo-GIA Tri-Staple instrument through the fourth port after extending the incision to 1.5-2.0 cm (Fig. D). The jejunal mesentery was fully released (Fig. E). To minimize the redundant Roux loop, an individualized jejunal Roux loop length was tailored by the distance between the umbilicus and the hepatic hilum [9]. The Roux loop was passed up to the hilum retrocolically. A side-hole

jejunotomy was created on the antimesenteric border 1 cm from the end of the jejunal limb to match the diameter of the hepatic duct. End-to-side hepaticojejunal anastomosis was accomplished laparoscopically with continuous 5-0 or 6-0 PDS sutures (Fig. F, Fig. G). Then, the Endo-GIA Tri-Staple instrument was used to complete the jejunal side-to-side anastomosis (Fig. H). The residual stoma was closed using continuous 5-0 PDS sutures, and the seromuscular layer was reinforced using intermittent 5-0 PDS sutures (Fig. I).

### 2.1.2 Conventional laparoscopic CDC excision and Roux-en-Y hepaticojejunostomy

The trocar locations, cyst excision and Roux-en-Y hepaticojejunostomy were all consistent with those in the TLH group; the main difference was that the end-to-side jejunum-jejunum anastomosis was performed via extracorporeal manual sewing. The specific procedures were as follows: The ligament of Treitz was identified under laparoscopy, and the proximal jejunum 20 cm distal to the ligament was captured with a bowel clamp and exteriorized through umbilical trocar site after extending the incision to 1.5 or 2.0 cm. Roux-en-Y end-to-side jejunojejunostomy with 2-layer interrupted sutures was carried out manually outside the abdomen. The closed jejunum limb was then lifted through an incision in the right side of the mesocolon to accomplish the end-to-side hepaticojejunal anastomosis.

Postoperatively, the patients were allowed to start oral intake when they meet the following standards: (1) no abdominal distension; (2) light gastric juice color with volume < 20 ml/d; (3) patients had passage of flatus and recovery of bowel sound. When patients were afebrile, no need intravenous fluids, wound healing well and blood test results were normal, they were discharged.

## 2.2 Follow up

All patients were followed 1, 3, 6, and 12 months postoperatively and every 6 months thereafter. Physical examination, abdominal ultrasonography, and laboratory tests were performed at each visit. Postoperative complications, such as pancreatitis, anastomotic stenosis, intrahepatic stone formation and pancreatic calculi formation, were evaluated clinically and with appropriate investigations.

## 2.3 Statistical analysis

Data were analyzed with the SPSS 21.0 package.  $\chi^2$  tests were performed to compare the distribution of sex, CDC type and postoperative complications between the TLH and CLH group. Student *t* tests were applied to compare the age, CDC length, CDC diameter, time to oral intake, postoperative hospital stay, hospitalization expenses, intraoperative blood loss and time for jejunum-co-jejunum anastomosis. A level of  $P < 0.05$  was considered statistically significant.

# 3. Results

In our study, 55 patients (TLH=30, CLH=25) with a diagnosis of CDCs underwent cyst resection and end-to-side hepaticojejunostomy. There were no significant differences in the demographic variables or pathological manifestations of the cysts between the two groups (Table 1).

The postoperative hospital stay and time to oral intake in the TLH group were significantly shorter than those in the CLH group ( $5.50\pm 0.28$  d vs  $7.00\pm 0.74$ ,  $P<0.05$ ;  $3.57\pm 0.19$  vs  $4.56\pm 0.27$ ,  $P<0.01$ ). It is worth noting that the hospitalization cost in the TLH group was significantly higher than that in the CLH group (CNY  $40085\pm 2447$  vs CNY  $26084\pm 2776$ ,  $P<0.001$ ). There were no significant differences in the intraoperative blood loss volume, time for jejunum-co-jejunum anastomosis or complications between the two groups (Table 2).

The median follow-up periods of TLH and CLH group were 17 (11-27 months) and 16 (11-27 months) months respectively. All patients, except for those mentioned below, were free of abdominal pain, fever and jaundice. Group TLH has 3 postoperative complications, one occurred obstruction and necrosis 1 week after discharge (2 weeks after operation), because [the distal biliary jejunum herniated from the transverse mesocolic hiatus into the colon and compressed the proximal biliary jejunum](#), and choledochojejunostomy was performed again. One case presented adhesive intestinal obstruction 1 month after discharge (1 month after surgery), which was improved after conservative treatment. One patient underwent choledochojejunostomy again 1 month after discharge (1 month after surgery) because of severe adhesion in the abdominal cavity due to suppurative appendicitis and obstruction necrosis due to cord compression of proximal biliary jejunum.

Group CLH has 2 postoperative complications. One patient presented intestinal obstruction 1 week after operation, no relief was found after conservative treatment, it was found to be caused by umbilical incision and intestinal tube adhesion via reoperation. One patient presented fever, abdominal bloating, increased leucocyte and amylase at 1 week after the operation, and ultrasonic examination indicated peritoneal effusion, which was not improved after conservative treatment, and pancreatic fistula was confirmed by surgery again.

## 4. Discussion

CDCs are a rare disease of bile duct dilation that was first proposed by Vater and Ezler in 1723 [10]. Although cysts are benign lesions, they are closely related to many serious complications, such as malignant bile duct tumors, cholangitis, pancreatitis and intrahepatic bile duct stones [2,11]. Therefore, surgery should be performed as soon as possible after the diagnosis is clear [12,13]. Compared with traditional open surgery, laparoscopic CDC surgery has the following advantages [14,15]: ☐ Laparoscopy can magnify the tissue 4-8 times, allowing precise separation of the cyst from the surrounding tissues, such as the hepatic artery, portal vein, pancreas and capillary network around the cyst, and thus avoiding side effects. ☐ Laparoscopy can penetrate into the hepatic hilum for a more accurate operation; meanwhile, bile duct abnormalities, such as labyrinthine bile duct and hepatic stenosis, can be visually detected. ☐ Laparoscopic surgery causes less intestinal disturbance and allows faster postoperative intestinal peristalsis recovery. ☐ The incision is small and aesthetic, and the pain is mild. The incidence of wound infection and incisional hernia is reduced after this operation. Total laparoscopic surgery, in addition to the above advantages, has an additional advantage that the umbilical incision is smaller and more aesthetic, which is more satisfactory according to the needs of children and their families.

In the CLH group, the bowel was pulled out through umbilical incision to complete jejunal end-to-side anastomosis. Intestinal traction and exposure increase the risk of intestinal injury and adhesions in theory. We successfully performed total laparoscopic CDC excision and Roux-en-Y hepaticojejunostomy in 30 children. Compared with the CLH group, the postoperative fasting time and hospitalization duration were significantly shorter in the TLH group. These findings show that the total laparoscopic approach disturbs the bowel less and allows the faster recovery of gastrointestinal function. However, it is worth noting that the hospitalization cost in the TLH group was significantly higher than that in the CLH group, which may be due to the high cost of laparoscopic instruments. With the continuous development of surgical instruments, we believe that in the near future, the cost of laparoscopic instruments will gradually decrease.

The main difference between TLH and CLH is jejunum-to-jejunum anastomosis. We need to pay attention to the following points: ☐ When the jejunum is cut using an endoscopic stapler, the intestinal tube should be fully flattened to avoid overlap, which could result in insufficient cutting and intestinal fistula. ☐ A side-hole jejunotomy was created on the antimesenteric border just 0.5 cm from the end of the proximal jejunum, to minimize the occurrence of a "blind pouch". ☐ When using an endoscopic cutter stapler for jejunal side-to-side anastomosis, the puncture hole in the intestinal wall need not be large. Its size should be suitable for placement at the end of the stapler to minimize the residual stoma and reduce the operative duration. Meanwhile, side-to-side anastomosis of the jejunum should be arranged in parallel with the mesentery to ensure full contact with the stapler. In the early stage of implementing total laparoscopic surgery, there was one case in which a child underwent jejunal side-to-side anastomosis with an uneven arrangement, resulting in excessive residual anastomosis, increased suture difficulties and a prolonged operation. In this study, the time for jejunal side-to-side anastomosis in the TLH group was longer than the time for jejunal end-to-side anastomosis in the CLH group, but there was no significant difference. We consider that this finding may be related to the learning curve for mastering total laparoscopic surgery.

Postoperative complications of laparoscopic CDC excision include pancreatitis [16], pancreatic fistula [17], cholangitis [1], biliary fistula and intestinal obstruction [18]. In this study, one child in the TLH group required reoperation because the distal biliary jejunum herniated from the transverse mesocolic hiatus and compressed the proximal biliary loops, resulting in obstruction and necrosis. The transverse mesocolon and gastrocolonic ligament are often thicker in older children with CDCs complicated with repeated infection; thus, we suggest that after establishing a retrocolonic tunnel to cross the transverse mesocolon, the gastrocolonic ligament should be fully separated at the same time so that the intestinal tube can pass smoothly. Subsequently, the hepatic limb jejunum and transverse mesocolon should be sutured intermittently for 3 to 4 needles to avoid obstruction caused by intestinal hernia. In the CLH group, one child developed a postoperative pancreatic fistula and needed reoperation to retain the abdominal drainage tube. We considered the pancreatic fistula to have been caused by too deep of an operating position when the distal end of the cyst was separated, resulting in damage to the pancreatic duct. Li et al. [19] believed that in children with cystic dilatation, not ligating the distal stump is a feasible approach and may minimize pancreatic duct injury.

The limitations of this study are that the number of cases is small, and follow-up period is short. The long-term effect in the two groups needs further study.

## 5. Conclusions

In summary, total laparoscopic CDC resection and Roux-en-Y hepaticojejunostomy are safe and feasible. Although the operation was still difficult because of the limited abdominal cavity capacity of children, resulting in a narrow operation space within delicate tissue, recovery was faster and the hospitalization duration was shorter in the TLH group than in the CLH group. Based on experience with radical laparoscopic CDC excision and intestinal anastomosis with a stapler, tacit cooperation and precise operations can ensure the safety and efficacy of the operation. In addition, the hospitalization cost in the TLH group was relatively high, so plans should be optimized for patients considering their family's economic situation.

## Abbreviations

TLH: total laparoscopic hepaticojejunostomy;

CLH: conventional laparoscopic hepaticojejunostomy;

CDC: choledochal cyst;

CT: computed tomography;

MRCP: magnetic resonance cholangiopancreatography

## Declarations

### **Ethics approval and consent to participate**

Ethical approval from the Institutional Review Board of Guangzhou Women and Children's Medical Center and written parental consent were obtained. The research was conducted in compliance with the World Medical Association Declaration of Helsinki.

### **Consent for publication**

A consent for publication is obtained from the patient in a written form.

### **Availability of data and materials**

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

### **Competing interests**

The authors declare that they have no competing interests.

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### **Authors' contributions**

All authors have read and approved the final manuscript. Study concept and design: FL, JXZ; Acquisition of data: XGX, BYT; Analysis and interpretation of data: MLL; Drafting of the manuscript: FL; Critical revision of the manuscript for important intellectual content: LL, QW, CWC, JXZ; Study supervision: JXZ.

### **Acknowledgements**

Not applicable.

## **References**

- 1 Atkinson HDE, Fischer CP, De Jong CHC, Madhavan KK, Parks RW, Garden OJ. Choledochal cysts in adults and their complications. *HPB(Oxford)*. 2003;5:105-110.
- 2 Soares KC, Arnaoutakis DJ, Kamel I, Rastegar N, Anders R, Maithel S, et al. Choledochal cysts: presentation, clinical differentiation, and management. *J Am Coll Surg*. 2014;219:1167-1180.
- 3 Silva-Baez H, Coello-Ramírez P, Ixtabalán-Escalante EM, Sotelo-Anaya E, Gallo-Morales M, Cordero-Estrada E, et al. Treatment of choledochal cyst in a pediatric population. A single institution experience of 15-years. Case series. *Ann Med Surg*. 2016;5:81-85.
- 4 Qiao G, Li L, Li S, Tang S, Wang B, Xi H, et al. Laparoscopic cyst excision and Roux-Y hepaticojejunostomy for children with choledochal cysts in China: a multicenter study. *Surg Endosc*.

2015; 29:140-144.

5 Farello GA, Cerofolini A, Rebonato M, Bergamaschi G, Ferrari C, Chiappetta A. Congenital choledochal cyst: video-guided laparoscopic treatment. *Surg Laparosc Endosc.* 1995;5:354-358.

6 Liu Y, Diao M, Li L. Using laparoscopic double hemicircumferential running single-layer suture in hepaticojejunostomy for choledochal cysts in children. *J Pediatr Surg.* 2018;53:199-202.

7 Sica M, Molinaro F, Angotti R, Bindi E, Brandigi E, Messina M. Choledochal cyst: Early experience by laparoscopic approach. *J Ped Surg Case Reports.* 2016;11:4-6.

8 Ahn SM, Jun JY, Lee WJ, Oh JT, Han SJ, Choi SH, et al. Laparoscopic total intracorporeal correction of choledochal cyst in pediatric population. *J Laparoendosc Adv Surg Tech.* 2009;19:683-686.

9 Diao M, Li L, Zhang JZ, Cheng W. A shorter loop in Roux-Y hepatojejunostomy reconstruction for choledochal cysts is equally effective: preliminary results of a prospective randomized study. *J Pediatr Surg.* 2010;45:845-847.

10 Vater A, Ezler C, Vater CA. *Dissertatio de Scirrhis viscerum occasione sectionis viri tymponite defunte.* Wittenburgae Pamphlets. 1723; 4:22.

11 Hamidi S, Livingston MH, Alnaqi A, Yousef Y, Walton M. Management of a massive choledochal cyst in a 12 year-old girl: Which imaging modalities should be performed preoperatively?. *J Ped Surg Case Reports.* 2016;10:42-46.

12 Diao M, Li L, Li Q, Ye M, Cheng W. Challenges and strategies for single-incision laparoscopic Roux-en-Y hepaticojejunostomy in managing giant choledochal cysts. *Int J Surg.* 2014;12:412-417.

13 Ryu HS, Lee JY, Kim DY, Kim SC, Namgoong JM. Minimally-invasive neonatal surgery: laparoscopic excision of choledochal cysts in neonates. *Ann Surg Treat Res.* 2019;97:21-26.

14 Choi SB, Choi SY. Current status and future perspective of laparoscopic surgery in hepatobiliary disease. *Kaohsiung J Med Sci.* 2016;32:281-291.

15 Mohammed Ilyas MI, Tieman J, Alkhoury F. Laparoscopic single stage procedure for perforated choledochal cyst. *J Ped Surg Case Reports.* 2015;3:436-439.

16 Fujishiro J, Masumoto K, Urita Y, Shinkai T, Gotoh C. Pancreatic complications in pediatric choledochal cysts. *J Pediatr Surg.* 2013;48:1897-1902.

17 Ohba G, Yamamoto H, Nakayama M, Honda S, Taketomi A. Single-stage operation for perforated choledochal cyst. *J Pediatr Surg.* 2018;53:653-655.

18 Diao M, Li L, Cheng W. Timing of surgery for prenatally diagnosed asymptomatic choledochal cysts: a prospective randomized study. *J Pediatr Surg.* 2012;47:506-512.

## Tables

**Table 1.** Demographics of the TLH group vs the CLH group.

	TLH group (n=30)	CLH group (n=25)	<i>P</i>
Sex (Male/Female)	8/22	6/19	0.82 <sup>a</sup>
Age (y)	4.31±0.46	3.62±0.50	0.30 <sup>b</sup>
CDC Todani classification (I/IV)	(1.3 y-12 y) 16/14	(30 d-10 y) 19/6	0.08 <sup>a</sup>
CDC length (mm)	46.47±4.35	45.56±3.59	0.88 <sup>b</sup>
CDC diameter (mm)	28.67±4.12	26.16±2.67	0.63 <sup>b</sup>

Values are mean±standard deviation.

<sup>a</sup>χ<sup>2</sup> test

<sup>b</sup>Student *t* test

**Table 2.** Perioperative characteristics of the TLH group vs the CLH group.

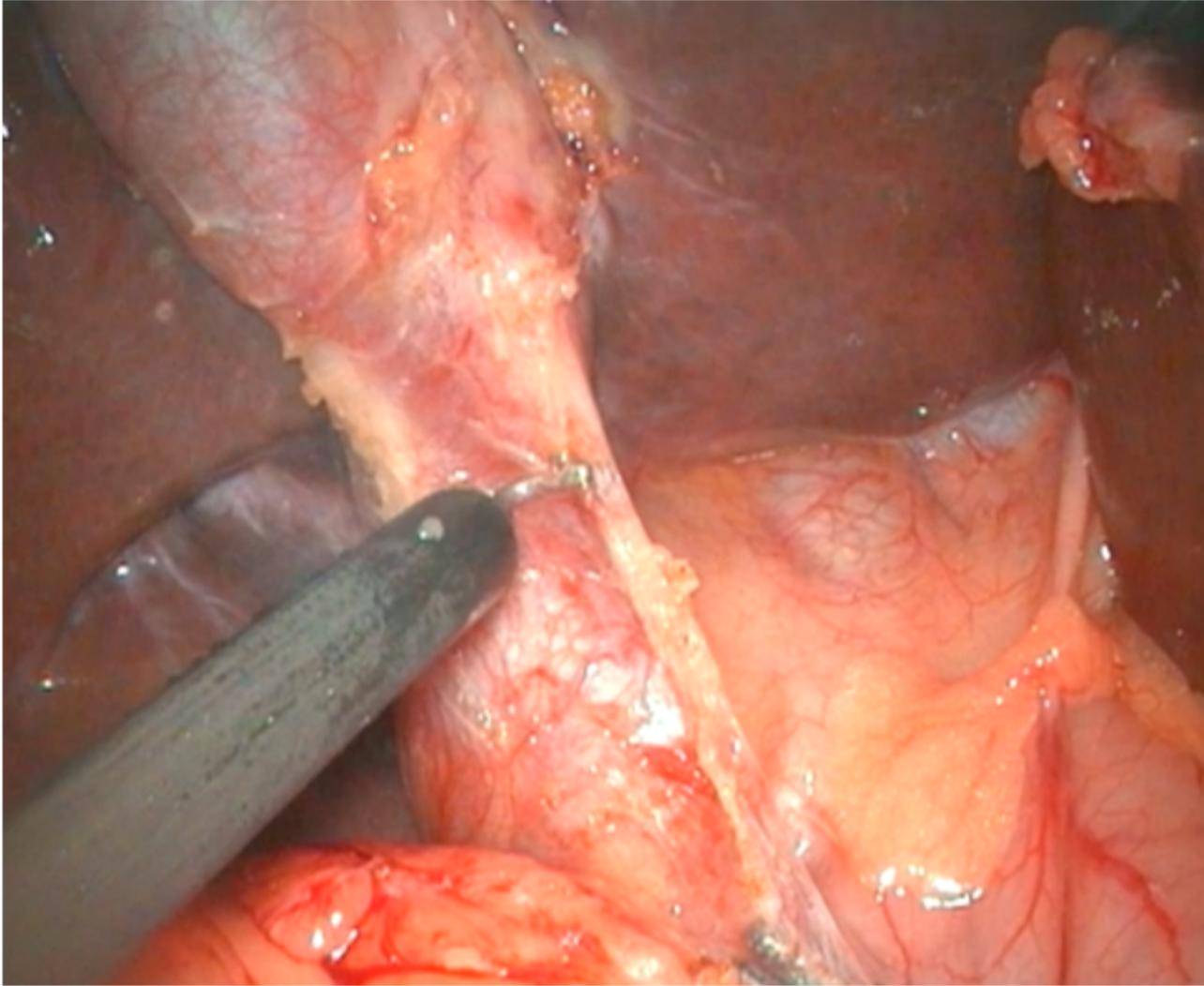
	TLH group (n=30)	CLH group (n=25)	<i>P</i>
Time to oral intake (days)	3.57±0.19	4.56±0.27	<0.01 <sup>b</sup>
Postoperative hospital stay (days)	5.50±0.28	7.00±0.74	<0.05 <sup>b</sup>
Hospitalization expenses (CNY)	40085±2447	26084±2776	<0.001 <sup>b</sup>
Intraoperative blood loss (ml)	9.57±3.28	8.20±1.13	0.72 <sup>b</sup>
Time for jejunum-co-jejunum anastomosis (min)	80.50±2.46	75.00±2.04	0.10 <sup>b</sup>
Postoperative complications (%)	3/30	2/25	0.79 <sup>a</sup>

Values are mean±standard deviation.

<sup>a</sup>  $\chi^2$  test

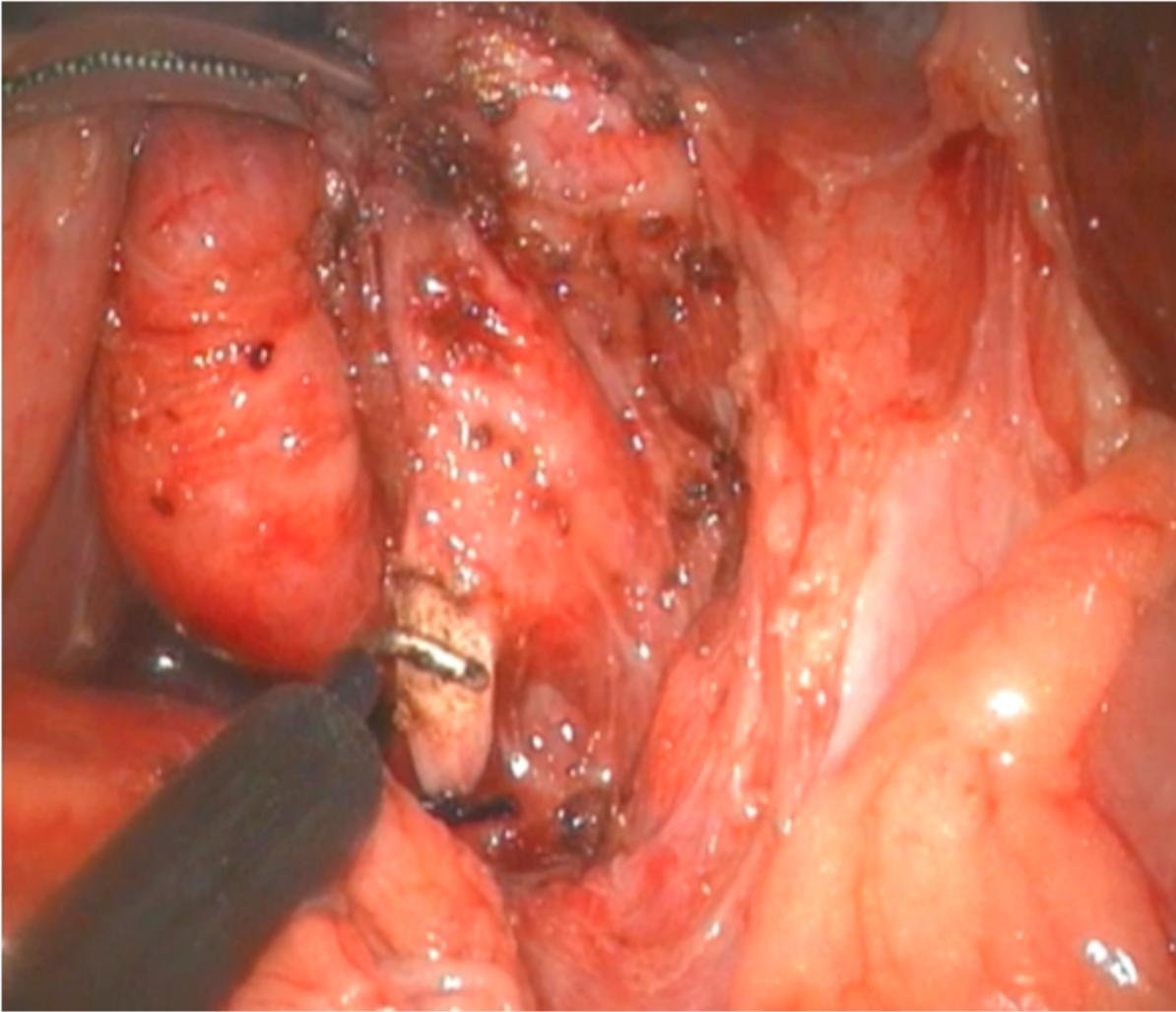
<sup>b</sup> Student *t* test

## Figures



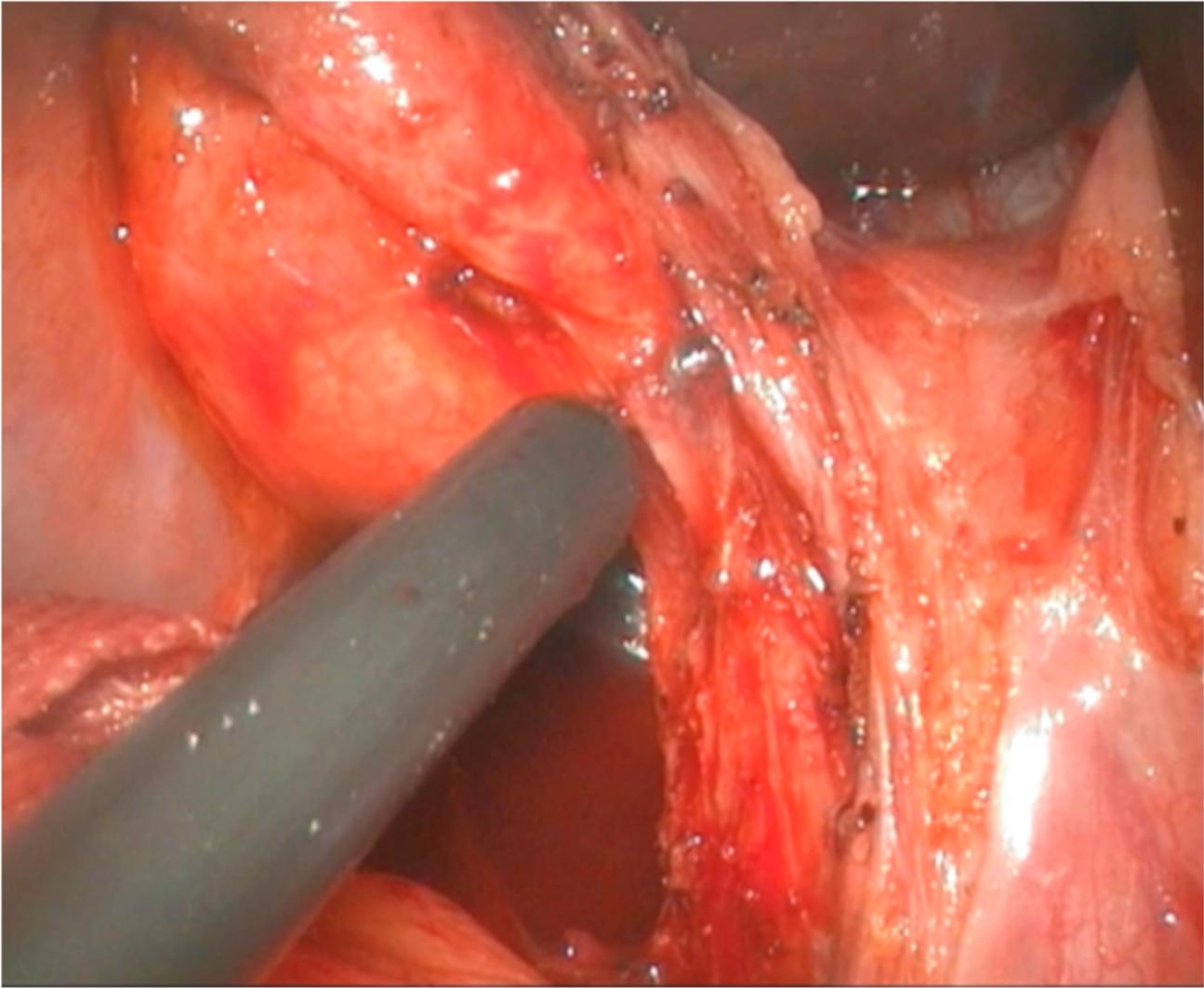
**Figure 1**

Separation of anterior wall of choledochal cyst



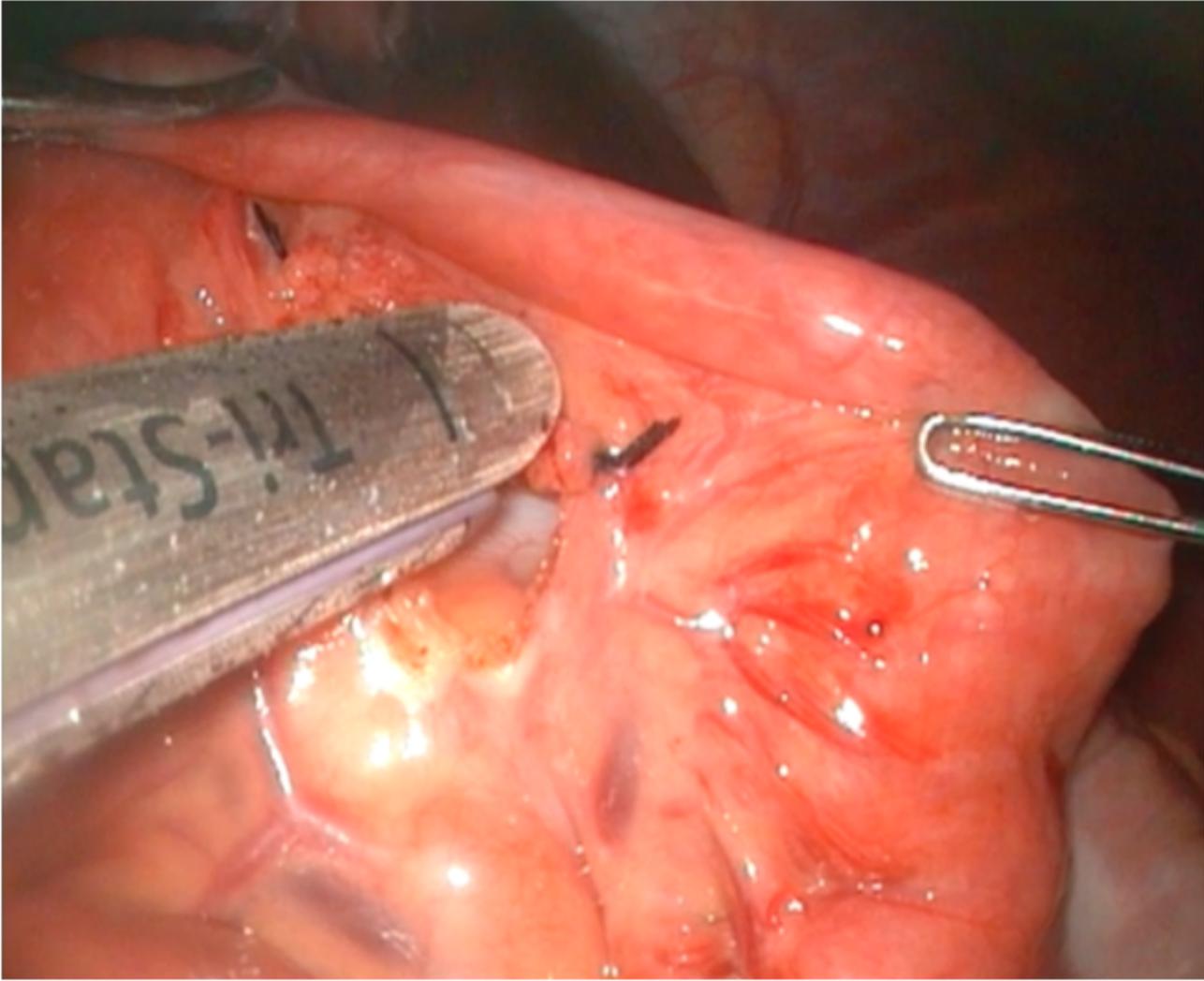
**Figure 2**

Separation of anterior wall of choledochal cyst



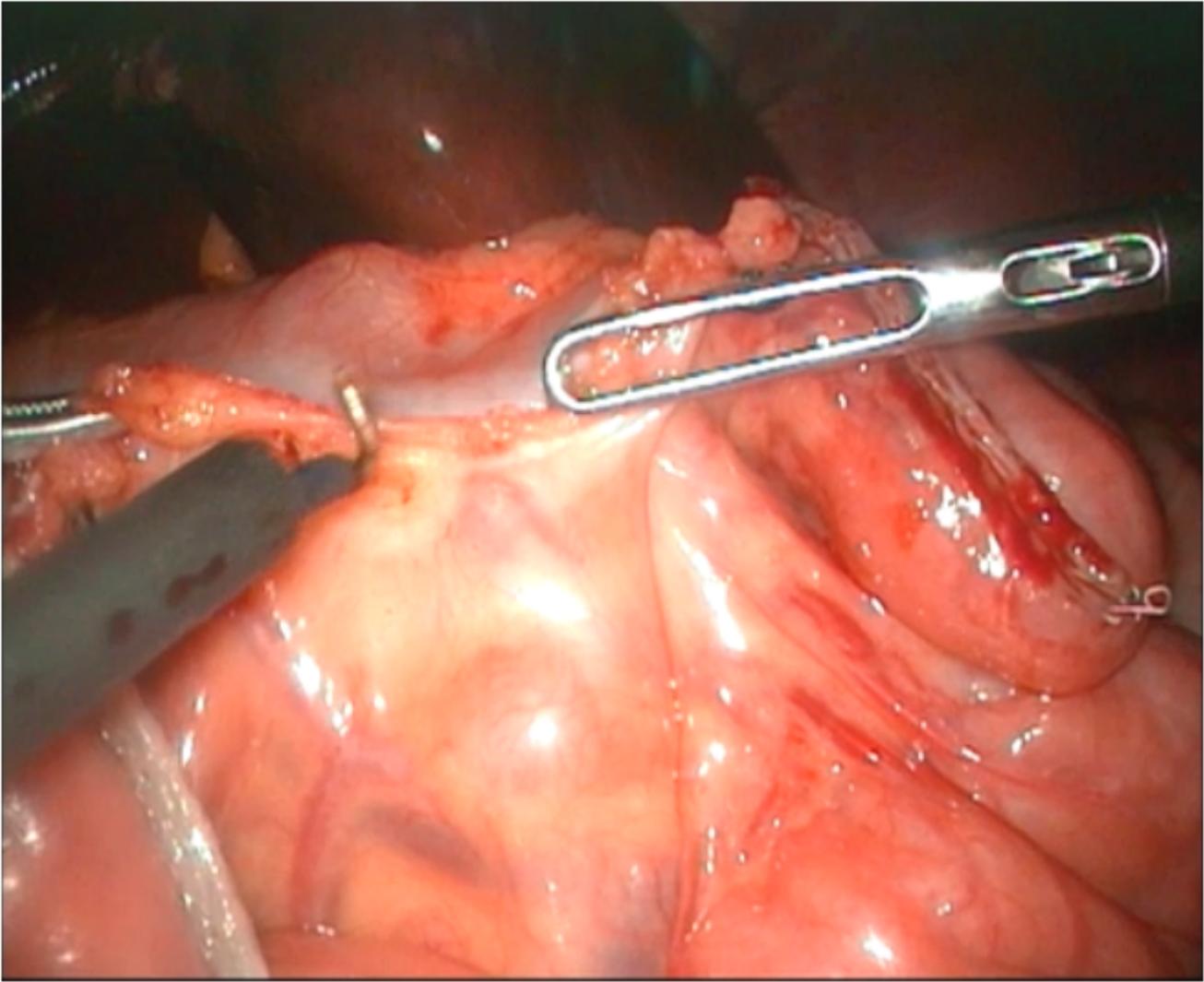
**Figure 3**

Separation of posterior wall of choledochal cyst



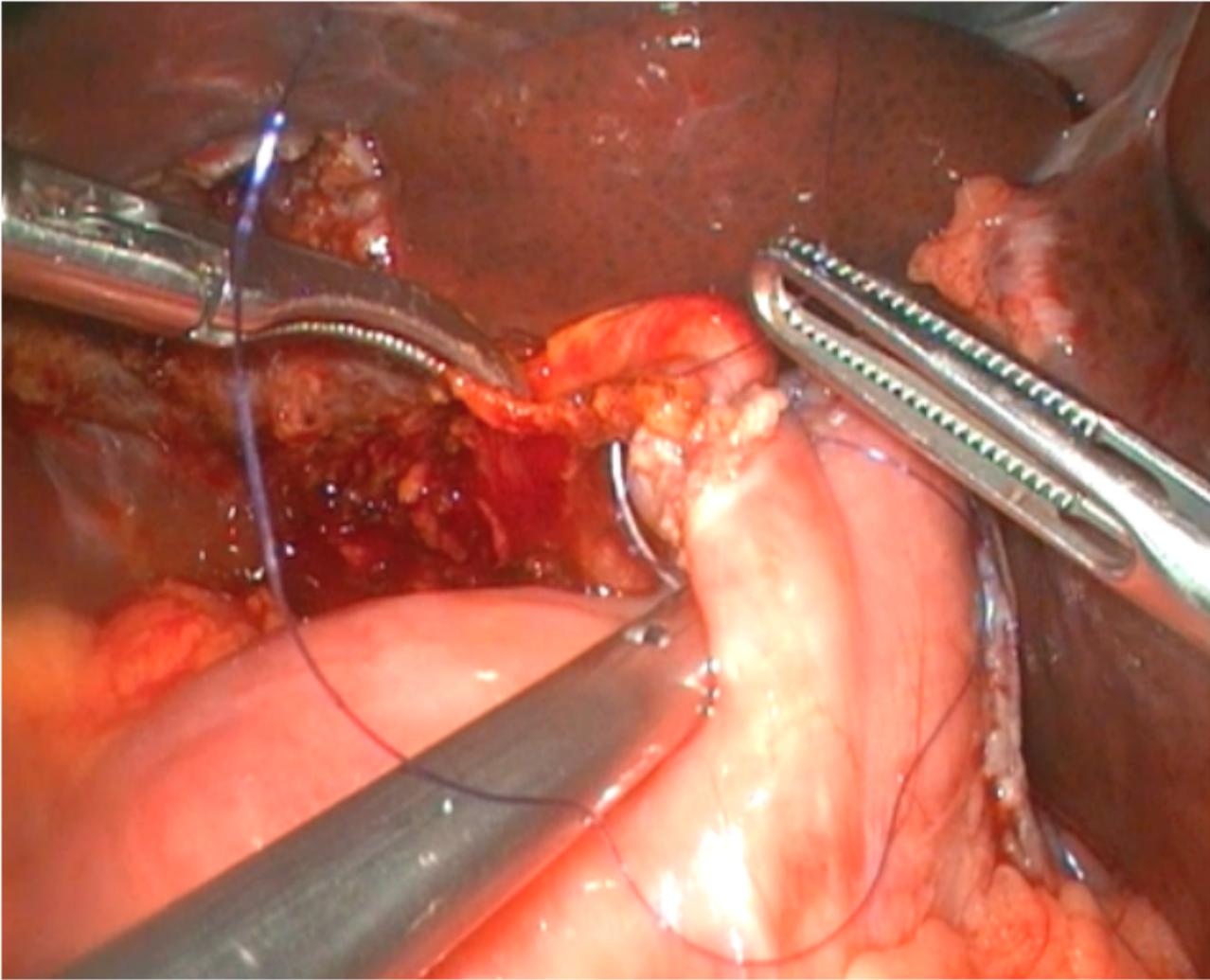
**Figure 4**

Excising proximal jejunum with Endo-GIA Tri-staple



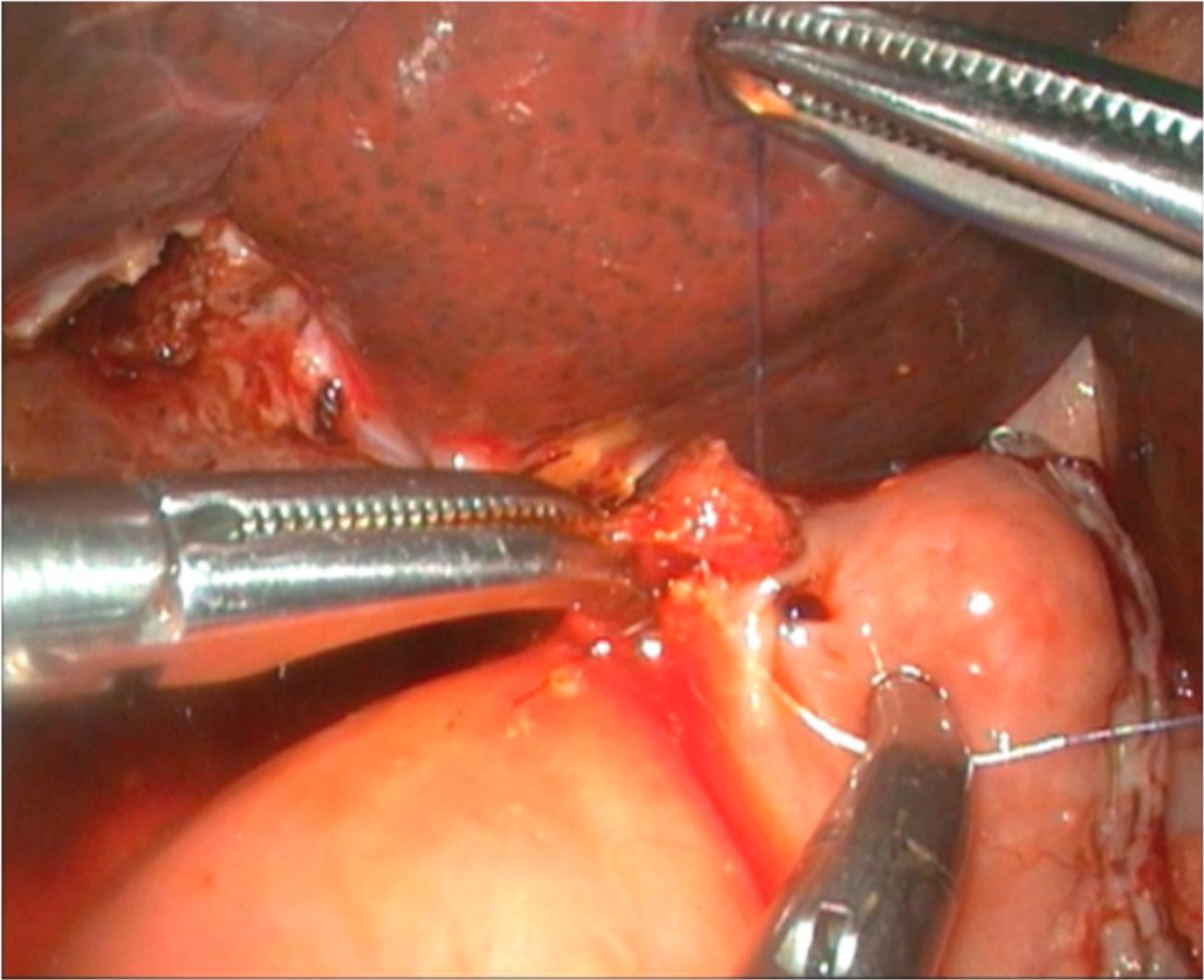
**Figure 5**

Fully releasing jejunal mesentery



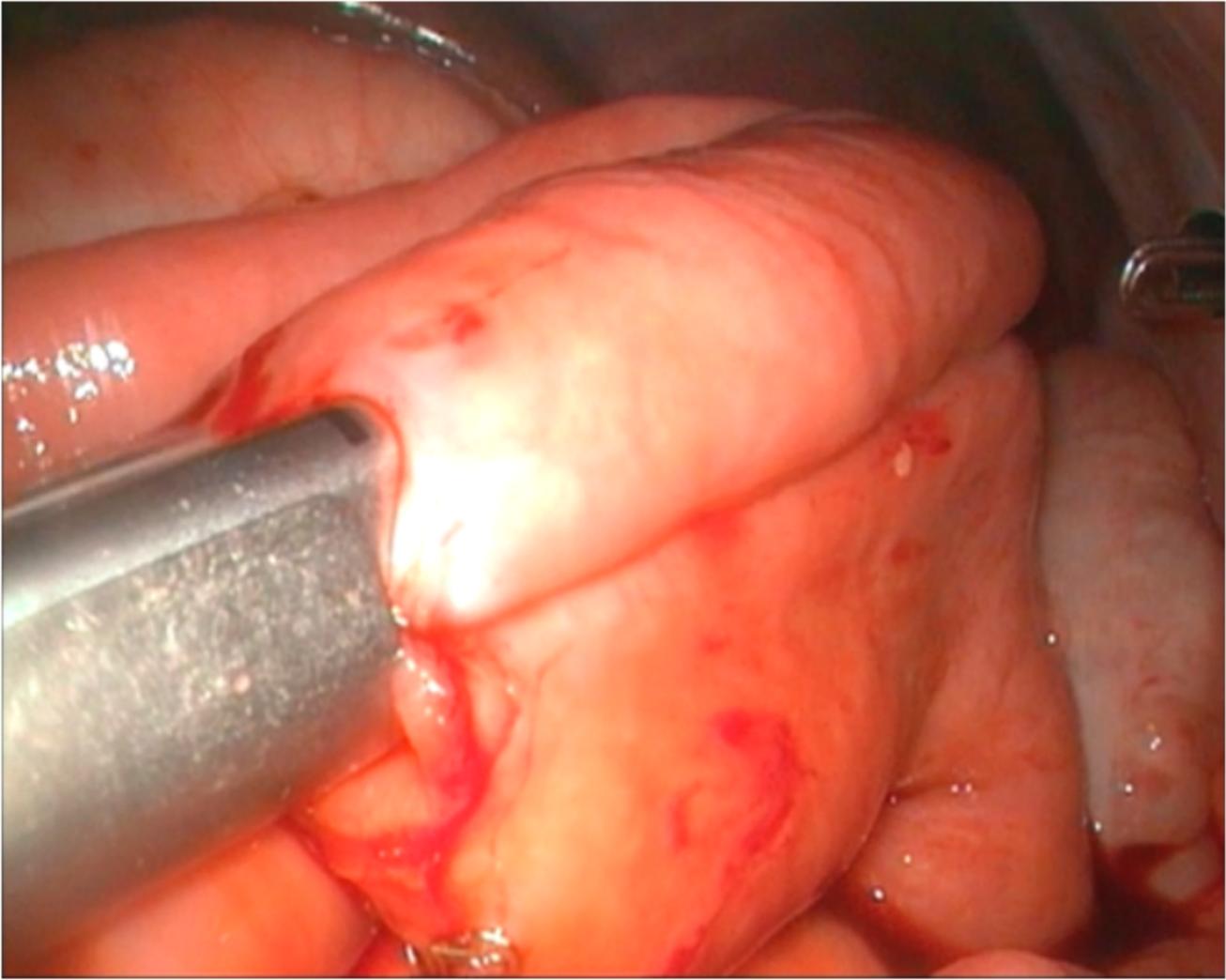
**Figure 6**

Posterior wall anastomosis during hepaticojejunostomy



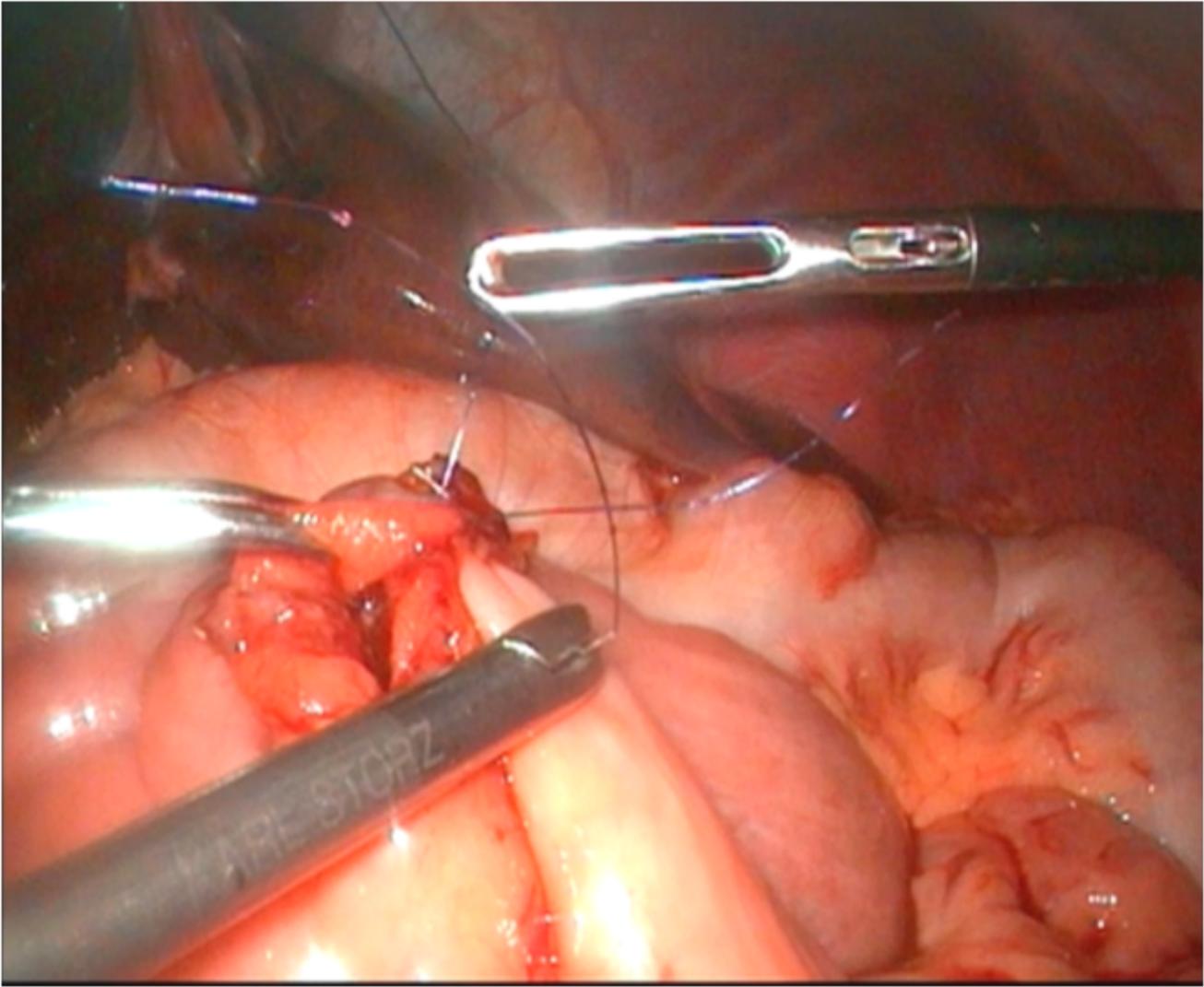
**Figure 7**

Anterior wall anastomosis during hepaticojejunostomy



**Figure 8**

Jejunal side-to-side anastomosis with Endo-GIA Tri-staple



**Figure 9**

Suturing residual anastomosis

## Supplementary Files

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