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Subtotal cholecystectomy *versus* cholecystostomy

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Dear Editor,

Emergency laparoscopic cholecystectomy (LC) is associated with a higher morbidity and mortality, as compared to elective LC. A two-fold increase in 30-day re-admission after LC was associated with two or more pre-operative admissions with symptoms of cholecystitis, as opposed to index-admission-LC (IALC). This was presumably because of more inflammation due to repeated attacks of cholecystitis in the former cohort, making gallbladders more “difficult”. Inflamed gallbladders with higher Nassar-scores (scores 3 and 4) also have significantly raised complication rates (1). Traditionally, “difficult-gallbladders” are dealt with using techniques such as cholecystostomy, subtotal-cholecystectomy (STC) and open surgery (2). Although, in the context of acutely inflamed gallbladders, tube-cholecystostomy initially decreases inflammation and acts as a bridge to definitive surgery (3), its overall effectiveness over LC or STC is still questionable (4). Moreover, robust evidence from NICE and AUGIS guidelines and our recent publication supports the role of early IALC in achieving significant clinical and financial benefits through a dedicated “hot-gallbladder” service (5). Furthermore, a recent meta-analysis studied the role of STC (73% laparoscopic) in “difficult-gallbladders”. Laparoscopic-STC (LSTC) had significantly lower mortality (0.4%), re-operation rates (1.8%), post-operative-ERCP (4.1%), retained bile duct stones (3.1%), post-operative infection (2.6%) and sub-hepatic collections (2.9%) and higher chances of bile leak (18%) as compared to open approach. They concluded that LSTC is effective for “difficult-gallbladders” and has a similar morbidity to LC in simple cases (2). One can therefore argue that a single step early LSTC or LC would be a more appropriate

approach in expert hands, especially in younger patients with “difficult-gallbladders”, rather than a two-stage procedure involving tube-cholecystostomy. The latter should only be reserved as a single-stage procedure to optimize older patients who are unfit for surgery.

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