

Laparoscopic Cholecystectomy for Acute Cholecystitis: Golden Hours Debatable Again

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Cholecystitis is inflammation of the gallbladder that occurs most commonly because of an obstruction of the cystic duct by gallstones (GBS) arising from the gallbladder (cholelithiasis) [1].

Gallstone (GBS) disease is common and considered as a leading cause for hospital admissions related to gastrointestinal problems.

Up to 20% of population will develop gallstone at some time [2] but up to 80% will never experience biliary pain or complications such as acute cholecystitis, cholangitis, bile duct obstruction, or pancreatitis [3].

Ninety percent of cases of cholecystitis involve stones in the gallbladder (i.e. calculous cholecystitis), with the other 10% of cases representing acalculous cholecystitis [4].

Laparoscopic cholecystectomy has been established as the treatment of choice for the management of acute cholecystitis. Several prospective randomized trials suggest the superiority of early (within 72h) over the delayed (after a few weeks interval) intervention. This 72 hrs limit, however, is difficult to be kept in many cases for a variety of reasons, referring to both patients and physicians. The speculation of a worse outcome, when attempting laparoscopic cholecystectomy for acute cholecystitis during the urgent admission beyond this very early phase, is experience rather than evidence-based [5].

Many studies have shown that same admission laparoscopic cholecystectomy (SALC) is superior to delayed laparoscopic cholecystectomy for acute cholecystitis (AC). While some proposed a "golden 72- hour" for SALC, the optimal timing remains controversial [6].

After IRB approval, local (Damascus) Retrospective analysis from a prospectively collected database between 2008 and 2012. Laparoscopic cholecystectomy for acute cholecystitis operated before and after 72 hours (72-240 hrs for delay presentation, missed diagnosis, prolonged per-operative preparation, long emergency OT list, and out-of-hand postponed surgery) of Hospital admission are included (the acute abdomen for any reason excluded) [7].

Laparoscopic cholecystectomy was performed in 436 patients with acute cholecystitis (108 male, 328 female). The average age was 41 years old (range 27 - 78 years). Laparoscopic cholecystectomy was performed within 72 hours of admission in 207 patients (group A) and after 72 hours in 229 patients (group B). Both groups were matched in terms of age, sex, body mass index, fever, white blood cell count, and ultrasound findings. No significant difference noticed in conversion rates between group A (3.4%) and group B (4.1%). The operation time was 80 versus 120 minutes. Complication rate was 2,2 % versus 3,48%, and in total hospital stay (3 vs. 5 days). Three patients required ERCP in group A and 7 in group B as a consequence of residual Choledocholithiasis. No deaths occurred in this study [7].

As the result, the laparoscopic cholecystectomy for acute cholecystitis performed within the same admission is safe and associated with low morbidity and almost no mortality, and preferably should be performed as early as possible, within the golden period of 72 hours after admission [7] and from the personal surgeon's perspective, the beyond 72 hrs the laparoscopic cholecystectomy for acute cholecystitis is accepted.

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