ECRONICON OPEN ACCESS

EC GASTROENTEROLOGY AND DIGESTIVE SYSTEM

Editorial

New Thinking on the Timing of Laparoscopic Cholecystectomy: A Point of View

Aswini K Pujahari*

Professor and Head, Department of Surgical Gastroenterology, Saptagiri Institute of Medical Science, and Research (SIM&RC), Bangalore, India

***Corresponding Author:** Aswini K Pujahari, Professor and Head, Department of Surgical Gastroenterology, Saptagiri Institute of Medical Science, and Research (SIM&RC), Bangalore, India.

Received: July 18, 2022; **Published:** July 19, 2022

DOI: 10.31080/ecgds.2022.09.00932

Gall stone disease (GSD) is highly prevalent and constitutes 20% in Europeans. 1 - 2% of this population become symptomatic annually. The low cost, easily available and non-invasive ultrasonography confirms the GSD [1]. Prof Dr Med Erich Mühe of Böblingen, Germany, performed the first laparoscopic cholecystectomy (LC) on September 12, 1985 and reported in 1996. The laparoscopic technology was made available by mid-1995. Many learners gave the initial complications of mostly bleeding and bile duct injuries giving the impression that LC is highly risky with high complication. With increasing experience on LC, complications, surgery time, conversion rate to open laparotomy started reducing. In a prospective study, 4498 Cholecystectomy done from 1990 to 2002, of whom 79% underwent LC and the conversion to open in 6.6% and the operation time, bleeding and bile duct injury (BDI) reduced markedly [2]. Around the same time nine (0.59%) BDI in 1522 LC was possibly the lowest [3]. Currently BDI has reduced to 0.2%, which can be detected at surgery by prior Indocyanine injection can be delt with at same surgery by experts [4]. The preoperative scoring for predicting the difficulty of LC makes patient's counselling better [5]. Our won study based on two years (2005-6) in 228 patients, easy LC with a score up to five and difficult with score of 6 - 10. It came true with a sensitivity and specificity of 75.00% and 90.24%, respectively. In this study, a single factor with highest score of 'four' of fifteen, was for hospitalisation for acute cholecystitis. These patient after conservative management, needed second admission for difficult interval LC. Twice hospitalization and LC obviously increase the cost. Presently, cholecystectomy is indicated only in symptomatic patients with sludge and stone. 33% patients got LC considered un-indicated [6]. This means, the person has to wait for unknown period after USG confirmation of GSD to become symptomatic, manage conservatively and get a difficult LC in second admission. Getting an acute pancreatitis during the waiting period can be fatal. Such a fatality has actually happed with a patient of the author due to delaying the LC by the patient. Similar fatality is also reported by others [7]. After biliary acute pancreatitis and if survived LC becomes difficult [7] (Image 1). When LC is performed as soon as stone is detected, before any attack, the gall bladder remains free of adhesion with normal anatomy. Thus, making the surgery easy and fast (Image 2). In such situation, recovery is quicker and hospitalization is short, which is confirmed on randomized controlled trial [8]. Let us learn from this finding of over 35 years work. Point of view after an acute attack of GSD, the surgery becomes difficult, longer with more chance complications leading to longer hospital stay. Time has come to perform LC as soon as GSD is confirmed on USG before acute attack to have a safe, quick surgery minimizing the complication and hospital stay.

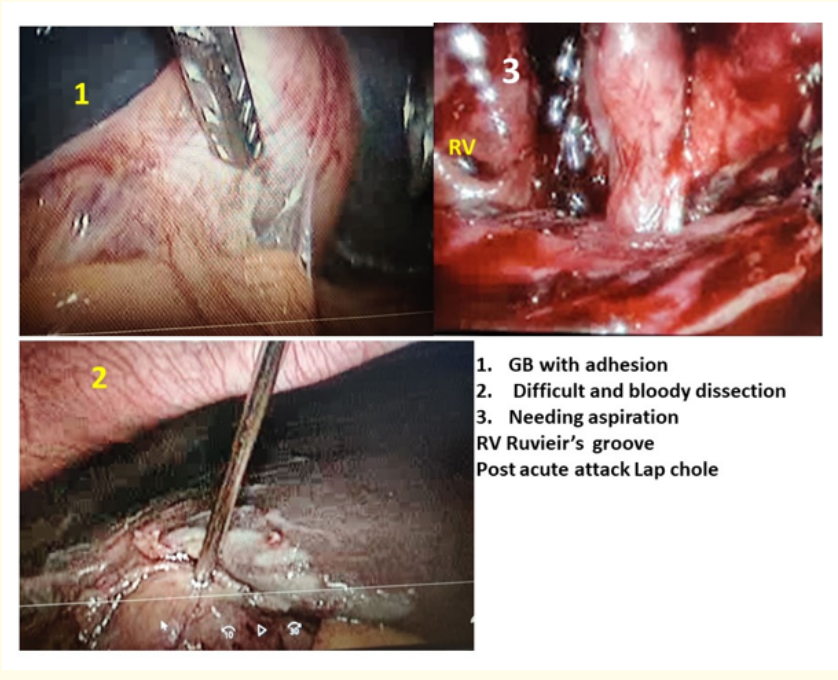

Image 1

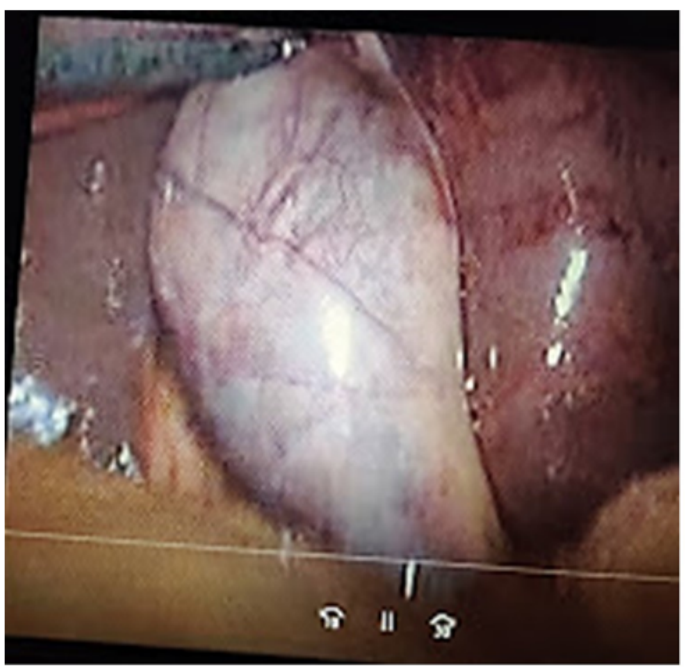

Image 2: *No adhesion, clean surgery possible.*

Conflict of Interest

Nil.

Source of Financial Support

Nil.

Bibliography

1. Katrin Hjaltadottir., et al. "[Gallstones - review]". *Laeknabladid* 106.10 (2020): 464-472.
2. B K Wölnerhanssen., *et al*. "Twelve years of laparoscopic cholecystectomy]". *Chirurg* 76 (2005): 263-269.
3. Virachai Mahatharadol 1 Bile duct injuries during laparoscopic cholecystectomy: an audit of 1522 cases Hepatogastroenterology 51.55 (2004): 12-14.
4. Dragos Serban., *et al*. "Systematic review of the role of indocyanine green nearinfrared fluorescence in safe laparoscopic cholecystectomy (Review)". *Experimental and Therapeutic Medicine* 23 (2022): 187.
5. N Veerank and MD Togale "Validation of a scoring system to predict difficult laparoscopic cholecystectomy: a one-year cross-sectional study". *Journal of the West African College of Surgeons* 8 (2018): 23-39.

6. Carsten Gutt., *et al*. "The Treatment of Gallstone Disease". *Deutsches Ärzteblatt International* 117 (2020): 148-158.

7. James Lucocq., *et al*. "Elective laparoscopic cholecystectomy: recurrent biliary admissions predispose to difficult cholecystectomy". *Surgical Endoscopy* (2022).

8. Benjamin Menahem., *et al*. "Delayed laparoscopic cholecystectomy increases the total hospital stay compared to an early laparoscopic cholecystectomy after acute cholecystitis: an updated meta-analysis of randomized controlled trials". *HPB* 17 (2015): 857-862.

Volume 9 Issue 7 July 2022