Authors' reply

Sir,

We appreciate the chance to respond to comments/queries made by our colleagues about our paper.[1] We work in a modestly equipped institution where laparoscopy is not available and our radiological colleagues are not very confident, vis-à-vis, various invasive interventional procedures. Perhaps surgeons working in elite institutions do not realize that many of us are working in hospitals where good quality imaging or expertise to use it is either not available or if available in private sector is beyond the patient's financial constraints. Hence the decision to go for an "Exploratory laparotomy", which remains not only the final court of appeal but also a very (if not the most) important 'investigation' for surgeons working in sub-optimal working conditions. Cholecystectomy was performed because hard nodule of 0.5 cm. X 0.5 cm. was palpable at the neck of gall bladder, gave an impression of impacted stone in the neck (this point has already been made in our paper). Ironically, (as mentioned in our paper) post-operative histopathological confirmation becomes the greatest tragedy of diagnosis because a condition that is curable medically has to follow surgery unavoidably.[2] We thank our colleagues for their interest in our paper.

REFERENCES

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Tanwani Rahul, Sharma Dhananjaya, Chandrakar Shiv Kumar

G-I Surgery Unit, Department of Surgery, and *Department of Pathology, Netaji Subhash Chandra Bose Government Medical College, Jabalpur - 482 003, India