Laparoscopic cholecystectomy: Underestimated!

Sir,

The article "Missed malignancies at laparoscopic cholecystectomy: a new emerging problem" is interesting.[1] We appreciate the authors' efforts of reminding the surgical community of the possibility of missing intraperitoneal malignancies at laparoscopic cholecystectomy (LC). This is not a new problem and is known since early 90s. They have concluded that the success of a treatment should not be compromised to merely utilize the minimally invasive approach. They have emphasized that careful evaluation of each patient, especially those with atypical symptoms, along with good visualization of the neighboring organs may aid in preventing such iatrogenic complications in future. Also, authors recommend careful use of LC in patients with doubtful diagnosis. In our opinion, their conclusions are debatable and undermine the diagnostic potential of laparoscopy. Although, authors have emphasized the importance of good clinical evaluation and diagnostic imaging, their inclination towards intra-operative diagnosis achieved by exploration of the peritoneal cavity by an open cholecystectomy (OC) is clearly noted in this article. We agree with the authors that there is a possibility to miss other pathologies at LC; however, we do not favor OC to overcome this problem. In the cases presented by the authors, the 'missed diagnosis' may not have been identified with certainty had OC been performed. Assuming that the missed pathologies were present at the initial presentation, there was a reasonable chance that they were identified. A good physical examination would identify ascites, lower abdominal lump; and an oesophago-gastro-duodenoscopy (OGD) performed on the basis of upper gastrointestinal symptoms would have identified gastric pathologies. Thorough history and routine blood tests may give an indication of underlying malignancy. If surgeons are treating 'ultrasound reports demonstrating gall stones' and not the patient's symptoms, it is poor clinical practice and we hope that is not the case. If symptoms are because of any other pathology, perhaps that patient may not need cholecystectomy!

It is incorrect to say LC leads to delay in the diagnosis, considering initial evaluation was thorough and additional tests were performed in suspicious cases. In this article, authors have not mentioned about the presenting symptoms and signs at the initial presentation. It is possible that the patients did not have any symptoms or signs at the initial presentation to suggest a malignancy. Whether OC would abolish this delay can only be answered by direct comparison between the incidences of 'missed pathologies' in two identical patient cohorts that underwent these two operations. Exposure with OC is far less from that with an exploratory laparotomy and may fail to identify intra-abdominal pathologies. On the other hand, laparoscopy can be an excellent tool to visualize peritoneal cavity and can certainly identify certain pathologies by inspection.[2-4] It is not difficult to convert LC to OC, should need arise, but not vice versa! In conclusion, we think thorough clinical evaluation, low threshold to add special investigations such as radiological imaging, endoscopy and tumor marker assays may minimize this problem and LC remains the gold-standard surgical treatment of uncomplicated gall stone disease.

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