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LETTER TO THE EDITOR

Reply to Letter Entitled "Timing and Mode of Surgery for Inflammatory Omental Cyst Questioned"

*Hsing-Lin Lin, Liang-Chi Kuo, Chao-Wen Chen, Yen-Ko Lin, Wei-Che Lee**

Sir,

We thank Dr Hung and Dr Shih for their comments on our article "Inflammatory Omental Cyst Adjacent to the Transverse Colon Mimicking Appendicitis in an Adult Patient."[1]

The first point was that our article did not mention the reading and interpretation of computed tomography scans by a radiologist, and that the role of the radiologist in the diagnosis of our patient was missing. This question draws attention to an important situation in Taiwan, namely that, in the middle of the night in some local hospitals, there are no radiologists available, and surgeons might have limited ability to interpret imaging studies. Our patient received treatment at midnight in a local hospital and there was no radiologist on duty. In addition to the lack of a radiologist's report, the availability of invasive procedures is also in question. However, the inflammatory omental cyst with suspected appendicitis was reported on by the radiologist the day after surgery. Therefore, the radiologist plays an important role in diagnosis because s/he can provide the surgeon with more information before operation.

With regard to the second point, we agree with Dr Hung and Dr Shih that the current practice for walled-off periappendiceal abscess favors nonsurgical management first, and then elective interval appendectomy later, if necessary, or even image-guided percutaneous drainage. Unfortunately, this was not the situation for our patient. If a radiologist had been available, the diagnosis might have been different, and drainage of the abscess possibly would have been recommended first. Nevertheless, because drainage does not offer adequate treatment of an omental cyst, should such a strategy have been undertaken, our case would still have been misdiagnosed initially as appendicitis.

The laparoscopic approach is another option if a radiologist is unavailable,[2] or when surgery is preferred. Enucleation could be the procedure of choice for cysts that are not connected to any normal structure.[3] Right hemicolectomy was performed in our patient because of the adhesion, giant cyst, and misinterpretation as periappendiceal abscess. The surgeon was afraid of compromising the blood supply to the other portion of the colon. Enucleation is surely not recommended in the treatment of omental cysts that are not connected to any normal structure. Thus, combined antibiotic treatment followed by segmental resection might have been a better choice for this patient. Fortunately, our patient did not have significant physiological consequences, such as malabsorption of bile salts and vitamin B_{12}, because of removal of the terminal ileum, after follow-up

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at our outpatient clinic. Dr Hung and Dr Shih expressed concern that inadequate work-up on our patient resulted in unnecessary, extensive right hemicolectomy. This is the reason why our case was reported—to remind surgeons to take greater care before operation.

During surgical training, encountering unexpected or difficult decisions is unavoidable, and sometimes leads to the wrong results. Only through the exchange of experience and the mistakes of others, especially with rarer cases, can surgeons avoid the same pitfalls and strive for excellence. We agree that quality assurance for surgery depends on sound surgical judgment and excellent technique to provide a tailored service to each patient. However, we think that problems continue to exist in local hospitals with limited resources, and backup support is required for surgeons who are struggling alone to provide emergency services, especially during the night or on weekends. However, practice should be improved through education and sharing of experience.

References

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3. Vanek VW, Phillips AK. Retroperitoneal, mesenteric, and omental cysts. *Arch Surg* 1984;119:838–42.