
Letters and Comment

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should be included only if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and to subedit contributions to ensure clarity

Is cholecystectomy effective treatment for symptomatic gallstones? Clinical outcome after long-term follow-up

We read the above article with interest (*Annals*, January 1998, vol 80, p25). We are particularly interested in this article as we have recently undertaken a similar study, but with conflicting results. First, our study was prospective and the present article was retrospective. Our patients' satisfaction was about 70% against the present publication which is surprisingly high at 93.5%. This is particularly difficult to understand when the article reports 28 patients of 102, ie some 30% with persistent postoperative pain. Does this count as complete satisfaction? Furthermore, in our study at least one-third of our patients developed a further symptom which was not present before surgery.

We would welcome the authors' comments.

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Authors' reply

We thank Mr Al Rawi and Mr Lewis for their interest in our paper. In this study, impression of outcome after cholecystectomy was scored by individual patients at structured interview in response to the overall degree of satisfaction, to which 93.5% of patients responded that they were satisfied. Tables II and IV provide data on absolute numbers of patients with persisting symptoms after cholecystectomy, while Figure 1 expresses this as outcome benefit ratios for defined symptoms. To summarise, abdominal pain persisted as a symptom in 30% of patients, fat intolerance in 28%, bloating in 20%, dyspepsia in 16% and heartburn in 14%. Assessment of outcome measured by doctors tends to be more critical than that of patients, and if this data were to be viewed from the medical standpoint, satisfaction after surgery is clearly not met. We addressed this issue in the discussion section, which questions the wisdom of assessing outcome after surgery by patient reporting alone. This is of particular relevance when evaluating outcome after cholecystectomy, where multiple variables are a component of the overall concept of satisfaction. Although doctors would well beware the pitfalls of adopting a wholly medical model of patient satisfaction, we would argue that relief of symptoms, derived from absolute numbers or outcome benefit ratios, is a more objective method of outcomes analysis after cholecystectomy. While our study is indeed retrospective, we have contended that this is an essential prerequisite in identifying outcome predictors to be tested for their statistical weightings in a prospective trial; Mr Al Rawi and Mr Lewis provide no

details of their own study. The onset of *de novo* symptoms after gallbladder excision is widely recognised. Previously published data is cited in our paper and our own findings reported in Table IV in respect of individual, rather than the presence of overall, symptoms. Finally, we would consider comparison of symptom prevalence after cholecystectomy to control groups (Figure 2) as an additional, perhaps more useful, mode of assessment of the effectiveness of cholecystectomy for symptomatic gallstones.

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Laparoscopic cholecystectomy, bile duct injury and the British and Irish surgeon

Torkington *et al.* (*Annals*, March 1998, vol 80, p119) tell us that the issue of intraoperative cholangiography (IOC) during laparoscopic cholecystectomy remains controversial and this statement is unquestionably true.

These authors sent a questionnaire to all consultant fellows of The Association of Surgeons of Great Britain and Ireland concerning their practice in regard to IOC. Only 33% replied, and of these 32% never performed IOC, 12% always did so and 56% "on a selective basis".

Any consideration of IOC must recognise that it has two completely different roles—to demonstrate/exclude common duct stones and to attempt to define biliary anatomy. There are many ways of dealing with common duct stones or potential stones; some involve IOC and some do not. Increasingly, less invasive modalities such as endoscopic and laparoscopic ultrasound are being used, but the policy adopted by each unit reasonably depends on local facilities and skills. It is crucial in any discussion of IOC to clearly define why the procedure has been carried out. Not only has the data collected in this study not been subjected to such analysis, there is no indication how often 'selective' cholangiography was done, or indeed on what basis the 'selection' was made.

The decision to consider only resection injuries is arbitrary and very difficult to justify. Any injury that interrupts the main ductal system, including a misplaced clip or a simple transection, constitutes a serious injury