

## Letters to the Editor

July 18, 1985

Dear Editor:

The paper by Hauer-Jensen et al.<sup>1</sup> has again raised some interesting questions on the current management of cholelithiasis. Isn't it time all patients undergoing cholecystectomy have a preoperative endoscopic retrograde cholangiography? If there is evidence of choledocholithiasis, an endoscopic sphincterotomy should be performed, and the patient referred for elective cholecystectomy. This will drastically reduce the need for surgical exploration of the common bile duct and we hope improve the associated morbidity and mortality. Unfortunately, this has yet to be confirmed in controlled clinical trials.

Until such time, however, peroperative cholangiography (PC) must be recommended for all patients undergoing cholecystectomy. It is one of the most sensitive tests for detecting choledocholithiasis.<sup>2</sup> Apart from its well-publicized advantages, it is useful in detecting unsuspected stones.<sup>3</sup> In their series,<sup>1</sup> 2% of the patients without any positive criteria had choledocholithiasis.

Iatrogenic damage is the most frequent cause of benign bile duct strictures, and over 90% of such injuries follow cholecystectomy.<sup>4</sup> In a series of 78 patients with postcholecystectomy biliary strictures,<sup>5</sup> over 70% did not have PC. It is important to define the biliary anatomy in all patients undergoing cholecystectomy, and PC offers a safe and easy method of achieving this.

There is everything to gain and very little to lose with routine use of PC. Even in the high risk patient, there are very few instances where PC is contraindicated on the grounds that it may significantly increase the time spent under anesthesia. Routine use of PC is strongly recommended.

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### References

1. Hauer-Jensen M, Karesen R, Nygaard K, et al. Predictive ability of choledocholithiasis indicators. *Ann Surg* 1985; 202:64-68.
2. Corlette MB, Schatzki S, Ackroyd F. Operative cholangiography and overlooked stones. *Arch Surg* 1978; 113:729-734.
3. Rolfsmeier ES, Bubrick MP, Kollitz PR, Onstad GR, Hitchcock CR. The value of operative cholangiography. *Surg Gynecol Obstet* 1982; 154:369-371.
4. Maingot R. The surgical aspects of non-malignant strictures of the bile ducts, with special reference to post-operative strictures. *Proc R Soc Med* 1960; 53:545-549.
5. Kelley CJ, Blumgart LH. Per-operative cholangiography and post-cholecystectomy biliary strictures. *Ann R Coll Surg Engl* 1985; 67:93-95.

August 19, 1985

Dear Editor:

As Dr. Derodra states in his letter, endoscopic retrograde cholangiography (ERC) is doubtless of great value in the preoperative diagnosis and treatment of common bile duct calculi.

However, because of the costs and the small, but definite, risk of complications, we do not think that routine preoperative ERC in all patients with cholecystolithiasis is justified.

Routine peroperative cholangiography (PC) during cholecystectomy leads to the detection of a certain number of unsuspected common bile duct calculi and may possibly also prevent some cases of bile duct injury. However, the occurrence of false-positive investigations, possible morbidity due to PC,<sup>1,2</sup> the percentage of common bile duct calculi that pass spontaneously, and the relative ease and safety with which retained common bile duct calculi may be removed endoscopically must also be taken into consideration.

In our opinion, controlled clinical trials are necessary to determine whether routine PC is advantageous or not. In a prospective, randomized study of the consequences of PC in patients with no clinical criteria of choledocholithiasis,<sup>3</sup> the group of patients in which PC was omitted fared significantly better than the group in which PC was performed.

Therefore, we advocate the use of PC only in patients with suspected bile duct pathology or in order to define biliary anatomy when necessary.

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### References

1. Lygidakis NJ. Potential hazards of intraoperative cholangiography in patients with infected bile. *Gut* 1982; 23:1015-1018.
2. White TT, Hart MJ. Cholangiography and small duct injury. *Am J Surg* 1985; 149:640-643.
3. Hauer-Jensen M, Karesen R, Nygaard K, et al. Consequences of routine peroperative cholangiography for gallstone disease: a prospective, randomized study. *World J Surg* (in press).

August 8, 1985

Dear Editor:

We read with great interest Dr. Fonkalsrud's article "Endorectal Ileal Pullthrough with Isoperistaltic Ileal Reservoir for Colitis and Polyposis." We disagree, however, with the statement that techniques for removal of the rectal mucosa have become standardized. The usual technique for mucosal proctectomy requires separation of the rectal mucosa and submucosa from the underlying circular muscle. In patients with severe ulcerative colitis, this is often difficult to perform and sometimes impossible. In Dr. Fonkalsrud's own series, four patients with severe ulcerative colitis could not undergo mucosal proctectomy because of severe mucosal ulceration. Two patients required ultrasonic fragmentation of the rectal mucosa in order to perform the operation. It is not clear whether these were the same two patients in whom manual mucosal proctectomy was not initially possible. Also, Dr. Fonkalsrud states that the length of time required for standard mucosal proctectomy ranged from 1 to 2½ hours depending on the duration and severity of colitis.