Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The editor reserves the right to shorten letters and subedit contributions to ensure clarity.

COMMENT ON

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MN Khan, I Nordon, A Ghauri, C Ranaboldo, N Carty. Urgent cholecystectomy for acute cholecystitis in a district general hospital – is it feasible? *Ann R Coll Surg Engl* 2009; **91**: 30–4

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Urgent cholecystectomy for acute cholecystitis

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Khan *et al.* have produced a well-structured study which describes the introduction of urgent laparoscopic cholecystectomy for acute cholecystitis in a district general hospital.

A number of randomised trials^{1,2} have shown that performing early laparoscopic cholecystectomy for acute cholecystitis was better than delayed cholecystectomy; the issue is still, however, surrounded by controversy.

Although operation within the 'golden 96 hours' is suggested,³ it is our experience that, in a district general hospital, there are numerous logistic difficulties with regards to the time required for an accurate diagnosis based on the findings of an abdominal ultrasound scan and accommodating such operations on the emergency operating list.

As a result, we would like to ask whether a dedicated fast-track ultrasound service for the confirmation of acute cholecystitis had any impact on the quality and cost-effectiveness with regards to service provision in carrying out other emergency

and elective radiological investigation. Also, it would have been interesting to know the rationale for routinely placing a sub-hepatic drain in all cases and how long the drain was left *in situ*.

References

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AUTHORS' RESPONSE

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With regards to the efficacy of fast-track ultrasound service for these patients, our observation was that confirmation of the diagnosis and getting the radiological investigations was one of the major delays in offering these patients emergency cholecystectomy at our hospital. A fast-track, dedicated ultrasound service was set up for this purpose and this was separate from the on-call provision of radiology services. Although we did not carry out a proper cost-effective analysis, it was found that a rapid access to ultrasound service led to quicker decision making and resulted in more patients operated in a timely manner on the emergency list with good quality outcomes.

The acutely inflamed gallbladder poses a more technically demanding dissection with potential for an increase in bile leak rates.¹ The risk of bile leak after emergency cholecystectomy has been reported between 2–3%.² It has been our protocol to leave sub-hepatic drain in all cases having an emergency cholecystectomy. The drains were usually removed at 24 h.

References

1. Dominguez EP, Giammar D, Baumert J, Ruiz O. A prospective study of bile