Is Prophylactic Cholecystectomy Unnecessary?

BY KATE JOHNSON
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MIAMI BEACH — Although prophylactic cholecystectomy is recommended by some surgeons for patients undergoing bariatric surgery, pharmacologic prophylaxis for cholelithiasis is adequate, according to Daniele Matera, M.D.

"Our study confirms the doubt of the strict necessity of prophylactic cholecystectomy in obesity surgery," he said at a congress on laparoscopy and minimally invasive surgery.

Morbid obesity is one of the major risk factors for gallbladder disease, and the risk is even greater following rapid weight loss—the goal of biliopancreatic diversion, explained Dr. Matera of the department of surgery at Catholic University of the Sacred Heart, Rome.

The literature contains evidence both for and against prophylactic cholecystectomy prior to biliopancreatic diversion, but there are operative risks that can be avoided with pharmacologic prophylaxis, Dr. Matera said at the congress, sponsored by the Society of Laparoendoscopic Surgeons.

The goal of the study was to evaluate the incidence of cholelithiasis and the role of medical prophylaxis in obese patients undergoing laparoscopic biliopancreatic diversion.

A total of 68 obese patients with negative preoperative hepatic ultrasonography were randomized to receive either laparoscopic biliopancreatic diversion with prophylactic cholecystectomy, or laparoscopic biliopancreatic diversion with postoperative medical prophylaxis consisting of ursodeoxycholic acid (600 mg) orally twice a day for 2 years.

The study suggests that the operative risks of prophylactic cholecystectomy can be avoided with the use of medical prophylaxis.

Patients in the medical prophylaxis group were followed for 2 years with periodic gallbladder ultrasound examinations. Symptomatic gallstones requiring cholecystectomy developed in only one (3%) patient during this period.

At 6 months, gallstones were present in three patients (8%), and gallbladder sludge was detected in two patients (6%).

At 12 months, gallstones were present in four patients (11%), and gallbladder sludge was detected in one patient (3%).

And at 24 months, gallstones were present in six patients (17%), and gallbladder sludge was detected in two patients (6%).

The study suggests that the operative risks of prophylactic cholecystectomy can be avoided with the use of medical prophylaxis, Dr. Matera said. ■

Cholecystectomy After Gallstone Pancreatitis

LOS ANGELES — When cholecystectomy is indicated following gallstone pancreatitis, the severity of the disease should determine timing of the surgery, Nicholas N. Nissen, M.D., said at the 12th International Symposium on Pancreatic and Biliary Endoscopy sponsored by the Cedars-Sinai Medical Center.

Surgical residents are traditionally taught to perform cholecystectomy before hospital discharge—and definitely within 4 weeks of symptom onset—to avoid complications.

That rule still holds for patients with mild or moderate gallstone pancreatitis.

But for patients with severe disease, it's a different story, noted Dr. Nissen, assistant surgical director of multiorgan transplantation and a specialist in minimally invasive liver and pancreas surgery at the medical center.

"Cholecystectomy in these patients should clearly wait until severe inflammation and organ dysfunction are resolved. It should certainly not be done in the first few weeks [after the onset of symptoms of severe gallstone pancreatitis]," said Dr. Nissen, who also serves on the surgical faculty at the University of California, Los Angeles.

—Betsy Bates