Letters to the Editor

Treatment of Asymptomatic Cholelithiasis

To the Editor:

Drs. Frame and Carlson have made a valuable, practical, and academically sound contribution to family practice in their series of articles on periodic health screening (*Frame PS, Carlson SJ: A critical review of periodic health screening using specific screening criteria. J Fam Pract 2: 29-36, 123-129, 189-194, 283-289, 1975*). Those involved in family medicine can be proud that this paper was written by family physicians.

There is one area, however, which I would like to examine more closely. In their section on cholelithiasis (*p 126*) the authors conclude that "asymptomatic gallstones should not be removed." However, they cite Peskin's article[1] and imply that it offers support for their opinion, when in fact, after reviewing the literature on the subject, Peskin strongly favors cholecystectomy for patients with asymptomatic gallstones. I believe we deserve an explanation for the authors' "opinion" on treating asymptomatic cholelithiasis.

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1. Peskin GW: The treatment of silent gallstones. Surg Clin North Am 53:1063-1069, 1973

The above letter was referred to Dr. Frame who replies as follows:

To the Editor:

Dr. Ely is correct in pointing out that Peskin[1] does advocate cholecystectomy for patients with asymptomatic gallstones. Our paper (*J Fam Pract 2:123-129, 1975*) stated that Peskin discussed the issue of the treatment of silent gallstones. We did not mean to imply that his conclusions agreed with ours. Indeed we disagree!

Peskin quotes Lund's series,[2] as did we, in which the mortality from gallbladder disease is one percent in patients aged 45 to 55 and seven percent in those over 65 without surgery. He compares this mortality with a surgical mortality of 0.3 percent and concludes surgery is preferred. Several observations about this comparison should be made. First, most of Lund's patients were *symptomatic* and were followed without surgery even after symptoms occurred. Had these patients been operated on after the first attack of symptoms (as is currently common medical practice), the mortality would probably have been much less than one percent. Likewise, the seven percent mortality in older patients would probably have been less had they not been followed conservatively after symptoms appeared. Second, 0.3 percent is the lowest surgical mortality reported. Other series report mortality rates of up to four percent in older, high-risk patients.

A mortality of 0.3 percent or higher may be a low risk for patients with painful or dangerous symptoms whose only effective remedy is surgery. Is it a low risk, however, for asymptomatic patients, 50 percent of whom will never develop symptoms and 50 percent of whom have not been shown to be at greater risk if surgery is delayed until the first attack of symptoms? We think not.

A valuable study, which to our knowledge has not been done, would be to screen all patients for gallstones and divide the asymptomatic positive cases into two groups. One group would have immediate cholecystectomy; the other would be watched until symptoms appeared and would have surgery at that time. Morbidity, mortality, and cost comparisons could be made between the two groups.

Paul S. Frame, MD
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1. Peskin GW: The treatment of silent gallstones. Surg Clin North Am 53:1063-1069, 1973
2. Lund J: Surgical indications in cholelithiasis. Ann Surg 151:153-162, 1960

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