

Primary prevention of gall stones in high risk populations may be an attractive proposition. Careful weight reduction and a high fibre diet are being advocated.²

What is the situation in Pakistan? Cholecystectomy is a common operation in large cities but seems to be infrequently performed in district general hospitals.¹⁰ Patients with asymptomatic stones rarely present at state run hospitals. Patients attending private hospitals with asymptomatic stones are either self supporting or have third party payers and generate different sorts of economic considerations. With regard to prophylactic cholecystectomy it is conceivable that a woman may only be able to afford cholecystectomy while her husband is still a beneficiary of an employee's social security scheme. Expectant treatment in a developing country has the additional handicap of poor follow up and access to hospital care during an emergency.

The prevalent stones have a lower cholesterol content as compared with the West and an infected etiology has been proposed.¹¹ In view of this, the natural history of stone disease is likely to be different. A higher incidence of gall bladder cancer has been reported.¹² The composition of our stones is likely to reduce success with medical dissolution therapy and ESWL. Other factors to consider in respect of non surgical treatment are patient compliance with long term medication and the availability of sophisticated technology. Primary prevention if at all practicable may need emphasis on different factors as compared with the West. Obesity is not regarded as a common risk factor in Pakistan; pregnancy is.¹³

On the whole, it would appear that it is a little more difficult to do away with cholecystectomy in a developing country but this should not stop us from looking cautiously at newer concepts and methods of managing cholelithiasis.

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EDITORIAL

Cholecystectomy: Present and future with special reference to Pakistan.

A little more than a 100 years after the first successful cholecystectomy the place of this operation in the management of cholecystolithiasis is beginning to be challenged. Although diagnosis of gall stones by ultrasonography is becoming common place, there is increasing trend towards carefully selecting patients for cholecystectomy. It has been proposed that only a minority (18%) of patients with asymptomatic stones go on to develop symptoms and complications attributable to the disease. A convincing argument has been made in favour of expectant treatment of silent gall stones on the grounds that it avoids unnecessary surgery and that it lowers the cost of health care. It does not appear that morbidity or mortality are increased as a result of a wait and watch policy. There is no evidence to suggest that there is a long lag period between the discovery of gall stones and the development of complications. Hence the argument that younger and healthier individuals with silent gall stones treated expectantly may come to grief in their old age as a result of the disease is not tenable. Also warning symptoms such as biliary pain as a rule precede the development of serious complications.

However, not every one is in agreement with expectant treatment of gall stones. Perhaps an even closer selection of patients with asymptomatic stones for expectant treatment is warranted. Cohort studies are in progress to define demographic features as well as stone and biliary tree characteristics that might accurately predict the development of symptoms and complications.²

Whether cholecystolithiasis causes vague dyspeptic symptom is questionable. Even after meticulous exclusion of other possible causes of dyspepsia if cholecystectomy is offered to such patients there is less than 70% chance of obtaining symptomatic relief.³

Although the occurrence of biliary pain is generally taken as indication for surgery, it is worth noting that a fair proportion of patients who avoid cholecystectomy will have no further symptoms.⁴

Paradoxically, the move towards exclusion of asymptomatic individuals from surgery comes at a time, when morbidity and mortality from cholecystectomy have been greatly reduced. Many centres advocate emergency cholecystectomy for acute cholecystitis and gall stone associated pancreatitis. Furthermore, in an attempt to reduce hospital stay and costs, 2-day admissions are being proposed for uneventful cholecystectomies.⁵

Alternative methods of treatment of gall stones have evolved. During the last 15 years interest in the medical dissolution of gall stones with bile acids has waxed and waned. It turns out that a relatively small proportion of symptomatic patients (10%) are suitable for this form of therapy.⁶

The criteria for selection for medical dissolution are translucent stones of less than 1.5 cms diameter in a functioning gall bladder. The duration of medical therapy may be as long as one or two years and its success rate is 70 percent. Unfortunately the recurrence rate is high at 50 percent but may be improved with the use of secondary preventive measures.⁷

More recently external shock wave lithotripsy combined with medical dissolution therapy has been successful. The combined physical and chemical modalities seem to be more efficacious than chemical treatment alone.⁸

On the other hand, endoscopic sphincterotomy and stone retrieval from the common bile duct does not preclude cholecystectomy because of the high incidence of acute cholecystitis developing at a future date.⁹