Journal of Gastrointestinal Surgery (2023) 27:2034
https://doi.org/10.1007/s11605-023-05785-8

LETTER TO EDITOR

Challenging Orthodoxy: Beyond the Critical View of Safety

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Received: 24 June 2023 / Accepted: 1 July 2023 / Published online: 17 July 2023

We read with great interest the article by Ostapenko and Kleiner,[1] which summarizes observations, whose publication has been pending for some time and which define a concern regarding the identification of tubular structures during laparoscopic cholecystectomy under the prism of the critical view of safety.

Allow us to expand their findings by pointing out the following.

A. "The dissection of the gallbladder up to the parallel portion of the cystic plate" described by the authors is mandatory [2] and in our opinion technically the most demanding part during the dissection of the structures, to accomplish the third criterion of the critical view of safety.

B. Unfortunately, until today, a generally accepted and widespread nomenclature of the anatomy in laparoscopic cholecystectomy, which would help the surgeon to gain confidence in the right identification and appropriate handling of the apparent vascular structure, is missing.[3] Of great importance arises the atypical pattern of arterial supply encountered during laparoscopic cholecystectomy dissection. One typical example of confusion is the so called "recurrent cystic artery" which is defined differently in various publications.[4,5] We completely agree with the way Ostapenko and Kleiner render and classify the recurrent cystic artery among the photographic material. Another debate refers to the term "dominant" for the posterior cystic artery which we consider produces more confusion than help in the clarification of vascular anatomy. We believe that the term "dominant posterior cystic artery" should be replaced by "double" or "dual" cystic artery.

C. It is very important when discussing the problem of identification of the vascular structures in the hepatocystic triangle to underline the possibility to encounter a caterpillar hump right hepatic artery that should not be mistaken as the cystic artery or one of two—dual—cystic arteries.[6]

The authors made a very strong point stating that "we must not grow complacent in our awareness of the variability in human anatomy. Guidelines and protocols exist to augment our cognitive and technical processes, though not replace them." Nevertheless, we think that their results do not challenge the orthodoxy of the critical view of safety. On the contrary it is the imperative necessity of meticulous dissection implied by the methodology of the critical view of safety that challenges the surgeon to understand thoroughly the vascular pattern which he or she is dealing with. And this requires a common anatomical language for the surgeon which is not available. Only with the assistance of this language will the surgeon be capable to know that the three dissected structures are eventually only two: a cystic duct and a cystic artery as represented in each one of the three described patterns in this article.

Due to the type of the study and the type of our publication (letter to the editor regarding the study), there is no need for ethical approval. The authors claim no conflict of interest.

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