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The use of laparoscopic subtotal cholecystectomy for complicated cholelithiasis

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Dear Editor:

We read with interest the article entitled The Use of Laparoscopic Subtotal Cholecystectomy for Complicated Cholelithiasis published in *Surgical Endoscopy* [1]. We congratulate the authors for their results, and we agree with their conclusion that laparoscopic subtotal cholecystectomy (LSC) is a valuable procedure during laparoscopic cholecystectomy (LC) when Calot's triangle cannot be dissected and that it will prevent unnecessary laparotomy. We have adopted this approach for many years in our busy LC practice.

We raise two issues we consider complementary to the valuable contents of the article. With LSC, there is always a risk of missing a stone in the cystic duct or residual part of Hartman's pouch because it is inaccessible or difficult to dissect. This may lead to occasional recurrence of right upper quadrant pain, which needs to be managed accordingly.

Although LSC without cystic duct ligation has been described as a practical alternative even with predictable bile leak [2], we have attempted closure of the "stump" whether this stump is the junction of the cystic duct to Hartman's pouch or part of Hartman's pouch. Ideally, this closure can be achieved safely with Vicryl endoloops. However, dissection of the posterior wall occasionally is compromised and unsafe, in which case we have closed the stump by a running suture that takes the anterior and posterior part of the stump which is adherent to the liver bed. These maneuvers have helped us keep biliary leak rates very low in our series.

References

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