Letter to Editor: Incidence and risk factors of acute cholecystitis after cardiovascular surgery

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Dear Editor,

I have been reading the article title “Incidence and risk factors of acute cholecystitis after cardiovascular surgery” in the General Thoracic and Cardiovascular Surgery [1].

The authors defined the diagnosis of acute cholecystitis according to predefined criteria, local symptoms such as Murphy sign and right upper quadrant pain, systemic symptoms such as fever, elevated CRP level and leukocytosis; and according to radiographic findings such as those obtained from ultrasound and computed tomography [1]. The Tokyo Guideline, published in 2007, provides evidence-based definitions and treatment recommendations for acute cholecystitis. Updated in 2013 and 2018. While the Tokyo guideline determines the appropriate treatment method in acute cholecystitis, it also grades the severity of cholecystitis clinically, biochemically and radiologically [2]. As it is known, while mortality is 0–10% in patients with acute cholecystitis, mortality increases (23–40%) in patients with postoperative cholecystitis and calculous cholecystitis such as cardiovascular surgery [3]. Kamei et al. study showed that they performed 29.4% cholecystectomy, 13.7% percutaneous drainage, 3.9% cholecystectomy after drainage, and 52.9% medical treatment for cholecystitis [1]. Early cholecystectomy within 72 h of its onset is characterized by Grade III (severe) cholecystitis end-organ failure, and if tolerated by the patient, they are recommended to be treated with emergency gallbladder drainage and delayed cholecystectomy [2, 4]. Percutaneous transhepatic gallbladder drainage (PTGBD) is an alternative treatment option for patients with critical

acute cholecystitis with comorbidity [5]. Therefore, in the treatment of acute cholecystitis seen in patients undergoing cardiovascular surgery, first, early and late cholecystectomy should be considered after classification according to the Tokyo guideline, and PTGBD should be considered in risky patients and in patients with Grade III cholecystitis.

Best regards

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