

Is the appropriate timing for percutaneous cholecystostomy in acute cholecystitis a matter of concern?

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To the Editor,

I have read the original article entitled "What is the effect of percutaneous cholecystostomy in patients with acute cholecystitis? When is the right time for the procedure?" by Yirgin H. et al,^[1] published in *Ulusal Travma ve Acil Cerrahi Dergisi* (2023;29:1269-1279). I want to congratulate the authors on this successful original article and make some contributions.

In the management of acute cholecystitis, it is a well-known fact that laparoscopic surgery is the gold standard. According to the Tokyo guidelines (TG18), recommendations have been made for patient management based on the clinical condition of acute cholecystitis.^[2] The principle of "not only the disease but also the patient" is applicable here as well. For Grade I patients, early laparoscopic cholecystectomy is recommended, while for Grade II cholecystitis, urgent/early cholecystectomy is suggested for low-risk patients based on the American Society of Anesthesiologists physical status (ASA-PS) and Charlson comorbidity index (CCI) scores. For high-risk patients (ASA-PS ≥ 3 , CCI ≥ 6), percutaneous cholecystostomy is recommended. Grade III patients are advised to undergo urgent cholecystectomy or percutaneous cholecystostomy under the most suitable operative conditions.

In the article, the authors determined the eligibility of patients for percutaneous cholecystostomy based solely on the CCI, and the results of the ASA-PS score were not considered. It remains unclear how the decision was made to classify patients selected for percutaneous cholecystostomy as a high-risk group. Additionally, it was observed that percutaneous cholecystostomy was applied to low-risk patients with a CCI median value of 1 (1-2) regardless of the grade of cholecystitis.

According to our clinic's management protocol, patients with Grade I and II cholecystitis undergo direct cholecystectomy if they belong to the low-risk patient group (with the option of bailout procedures if necessary). However, in Grade III cholecystitis, where one or more organ failures have occurred, urgent surgery is performed if there are no high risks (assessed based on CCI and ASA-PS). If high risks are present, percutaneous cholecystostomy is performed as soon as feasible.

In acute cholecystitis, perhaps the most critical cases to focus on are those with Grade III cholecystitis. This is because the mortality rate is significantly higher in this group compared to others, emphasizing the crucial importance of every minute in this context.^[3] Therefore, I believe that the interventional procedure (cholecystectomy or percutaneous cholecystostomy) should be performed as soon as the organ systems are stabilized.

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