Health-related quality-of-life

Dear Editor,
The author has covered this upcoming subject in a very concise and comprehensive manner.[1] It has been clearly mentioned that surgical by-pass is still relevant in the palliation of malignant obstructive jaundice, in the better interest of the patient, especially in the under developed countries.

Although the endoscopic stenting is a desired palliative procedure, the paucity of technical expertise, non-availability of adequate set up, and cost factor remain the limiting factors. In these circumstances, cholecysto-jejunostomy, gastrojejunostomy, and jejuno-jejunos-
tomy still remain the standard procedure.

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REFERENCE

Gallbladder tuberculosis

Dear Editor,
We read the article ‘Tuberculosis of the gallbladder without associated gallstones or cystic duct obstruction’ by Tanwani et al. with interest. It is indeed remarkable that apart from the nodes the only other intra-abdominal visceral focus was found in the gallbladder. We however have a few reservations about the management of the case.

1. Why was an ultrasound guided FNAC/biopsy of the nodes not attempted?
2. Could an extraperitoneal approach to the iliac nodes for biopsy have avoided a laparotomy?
3. If laparotomy were required, wouldn't a laparoscopic biopsy be a better option?

4. We do not find a reasonable indication to do a cholecystectomy in this case, as tuberculosis was high on the cards and medical therapy is the main stay of treatment.

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Authors' reply

Sir,

We appreciate the chance to respond to comments/queries made by our colleagues about our paper.[1] We work in a modestly equipped institution where laparoscopy is not available and our radiological colleagues are not very confident, vis-à-vis, various invasive interventional procedures. Perhaps surgeons working in elite institutions do not realize that many of us are working in hospitals where good quality imaging or expertise to use it is either not available or if available in private sector is beyond the patient’s financial constraints. Hence the decision to go for an “Exploratory laparotomy”, which remains not only the final court of appeal but also a very (if not the most) important ‘investigation’ for surgeons working in sub-optimal working conditions. Cholecystectomy was performed because hard nodule of 0.5 cm. X 0.5 cm. was palpable at the neck of gall bladder, gave an impression of impacted stone in the neck (this point has already been made in our paper). Ironically, (as mentioned in our paper) post-operative histopathological confirmation becomes the greatest tragedy of diagnosis because a condition that is curable medically has to follow surgery unavoidably.[2] We thank our colleagues for their interest in our paper.