



Laparoscopic cholecystectomy for gallbladder polyp: looking for a clear indication and value

Francesco Taliente, Pietro Mascagni

Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy

Correspondence to: Pietro Mascagni, MD. Fondazione Policlinico Universitario Agostino Gemelli IRCCS, Via della Pineta Sacchetti, 217, 00168 Rome, Italy. Email: pietro.mascagni@unicatt.it.

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We read with interest the article by Ryong and colleagues on the use of laparoscopic cholecystectomy (LC) as prevention for gallbladder cancer. The manuscript focuses on the accidental discovery of gallbladder cancer following LC for gallbladder polyp and the occurrence of postcholecystectomy syndrome. The Pyongyang group present their experience with 292 LC performed for gallbladder polyps reporting a 7.2% incidence of malignant lesions and a rate of postcholecystectomy syndrome of 18.8%. They further note that incidence of malignancies rises with the age of patient and the size of polyps. However, the authors correctly point out that in their series 1.4% of polyp under 5 mm were malignant.

The indications to LC for gallbladder cancer prevention are still a matter of discussion. Gallbladder polyp size and patient's age are known risk factors and have been used for prophylactic LC indications (1). LC is commonly indicated when the polyp size is greater than 10 mm, however this threshold lacks evidences and it is being discussed (1,2). Indeed, in this Korean series 3 patients with smaller polyps presented a malignancy. To define the value of prophylactic LC following the finding of gallbladder polyps a comprehensive analysis of risks, costs and benefits is needed (3). This is much behind the scope of the manuscript by Ryong and colleagues.

A number of interesting questions arise from reading their paper. How does the polyp size correlate with histopathologic staging? LC alone is considered adequate for patients T1a whilst T1b/T2 cancers should undergo

extended cholecystectomy (removal of a rim of liver of 2 cm from the gallbladder bed) (4). Estimating the risk of a certain histopathologic stage from the polyp size could thus offer surgeons an actionable information. Furthermore, should we accept the concept of diagnostic LC? In the presented series 191 patients with no symptoms underwent LC because of the incidental finding of gallbladder polyps. It is true that up to now diagnostics have failed to discriminate between true and false polyps and, more importantly, between malignant and benign lesions (2). However, we believe that further research on risks factors and optimal non operative management of gallbladder polyps (5) should be encouraged to prevent surgeries on asymptomatic patients.

In conclusion, we thank Ryong *et al.* for disclosing their experience that certainly adds interesting observations to a topic in need of more high-quality evidences.

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