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Dear Editor,

Re: Enhanced Recovery After Surgery and laparoscopic colorectal surgery: where to now?

I read with interest both the editorial by Lubowski¹ and the paper by Shaikh and colleagues² on the respective role of laparoscopy and enhanced recovery after colorectal surgery. Dr Lubowski and Drs Shaikh and colleagues have to be congratulated as they pointed out hot and important aspects of our daily practice. Both the editorial and the original paper deserve, however, some comments. Regarding the benefits of laparoscopy without enhanced recovery pathway (advocated by Shaikh and colleagues), I assume that the authors were probably applying some elements of enhanced recovery without admitting this. We should not set laparoscopy against enhanced recovery programmes.

As we have shown, Kehlet and myself,³ the enhanced recovery programmes are no more no less than the actual implementation of every evidence-based perioperative care element. Everyone can admit that when we want to apply the principles of evidence-based medicine in our practice, we will necessarily implement many elements of enhanced recovery pathway. Laparoscopic colorectal surgery is part of these evidence-based elements. In this way, one cannot imagine to use laparoscopy without other evidence-based perioperative elements.

Dr Lubowski highlighted the lack of evidence regarding carbohydrate loading and thoracic epidurals. There is sufficient evidence in favour of carbohydrate loading before major surgery, as among three meta-analyses (references under request) suggested the safety and the beneficial effect of preoperative carbohydrate loading, even if its cost-effectiveness should be further assessed. The role of thoracic epidurals is now better evaluated, while it is important with laparotomy, it is more controversial in laparoscopic colorectal surgery.⁴ I also know that a recent randomized trial from Switzerland (accepted for publication in the *Annals of Surgery*, personal communication) showed that thoracic epidural analgesia is not superior to the alternative multimodal analgesia in laparoscopic colorectal surgery.

In my opinion, the debate on the choice between laparoscopy and enhanced recovery is over. From an ethically aspect, every evidence-based element (whether laparoscopy or others) should be implemented. The debate is at present on how to improve implementation in a large scale.

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doi: 10.1111/ans.12879

Dear Editor,

Response to Re: Enhanced Recovery After Surgery and laparoscopic colorectal surgery: where to now?

I thank Dr Slim for his letter¹ in response to both my editorial (Enhanced Recovery After Surgery and laparoscopic colorectal surgery: where to now?²) and to the perspective by Shaikh and colleagues.³ I am mindful of Dr Slim's experience and valuable contributions to the development of ERAS.⁴ I do not believe that there is actually too much that we disagree on. We have both stressed the central importance of only implementing evidence-based elements of perioperative care. ERAS has a number of different elements, and many ERAS trials do not include all of them. Some of them are inherently practiced after laparoscopic colectomy.

I am not suggesting that we should set minimally invasive techniques against ERAS. They are both important. I agree with Dr Slim that, in their report on laparoscopic colectomy and length of stay, Shaikh and colleagues were likely to be including some elements of ERAS,⁴ and perhaps those are the elements of ERAS that are needed to achieve the good outcomes Shaikh *et al.* reported.

One point where Dr Slim and I diverge is his suggestion that the ERAS debate should shift to 'implementation on a large scale'; I believe we should be cautious until we have more information on which specific elements will provide cost-effective clinical benefits in laparoscopic surgery. Indeed, Dr Slim has made the point that, for example, thoracic epidurals are more important with open than laparoscopic resection and that the cost-effectiveness of preoperative carbohydrate loading needs to be assessed. Allocating additional staff for implementing ERAS 'programmes' will be expensive, and perhaps having simple clinical pathways within a laparoscopic domain may achieve the same ends. An analogy may be found in the

implementation of day case surgery for haemorrhoidectomy, where many believed that formal programmes would be needed to supervise outpatient post-operative analgesia and fast-track readmission protocols. Changes in our approach to haemorrhoid surgery have made day case haemorrhoidectomy routine practice without elaborate protocol-driven funded programmes. Currently, there are still unanswered questions around ERAS and laparoscopic surgery, and hence my desire in the editorial to open up this discussion.

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doi: 10.1111/ans.12875

Dear Editor,

Re: Lateral cervical cysts: an Australian perspective

We refer to this interesting paper on lateral cervical cysts, published in early 2012.¹

This paper, among other points of interest, notes the predisposition of squamous cell carcinoma (SCC) of the oropharynx to metastasize to deep cervical lymph nodes and undergo cystic degeneration,² and thus the associated difficulty in differentiating these from branchial cleft cysts, especially in the absence of an identifiable primary malignancy.

We have noted in our institution that a significant proportion of cystic lesions in the parotid that were sampled by fine needle aspiration (FNA) for cytological assessment are metastatic SCC rather than a primary salivary gland lesion. We performed an audit of all FNAs of the parotid gland over a 2-year period. There were a total of 58 cystic lesions of the parotid identified. Of these, 17% (10 cases) were malignant, with seven (12%) reported as metastatic SCC, with a further three being highly suspicious for SCC (with either criteria not quite adequate for definite diagnosis of SCC or having a differential diagnosis of mucoepidermoid carcinoma).

The remaining cases were benign, consisting of a mixture of benign salivary gland tumours (Warthin and pleomorphic adenoma) and non-specific or mucoid cysts.

Dividing the cases into those over and under 40 showed that 13.5% (seven out of 42) of cystic masses in the over 40s were metastatic SCC. In the case of lesions localized to the parotid, the diagnosis of a branchial cleft cyst does not generally enter into the differential diagnosis, with Warthin's tumours being by far the most common cystic lesion of the parotid gland.

Our study reflects one of the original papers points, which is the need to consider metastatic SCC as a highly likely diagnosis in lateral cervical cysts, specifically, in our study, in cystic parotid lesions.

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doi: 10.1111/ans.12887

Dear Editor,

Prevalence of duplicate gallbladder in cholecystectomy patients

A duplicate gallbladder (DGB) is a rare congenital anomaly with a reported incidence of one in 3800 cadavers.¹ Prevalence of DGB among patients undergoing cholecystectomy is unknown. The aim of the study was to determine prevalence of DGB in cholecystectomy patients.

This was a retrospective cohort study. Over a 5-year period (May 2004 to June 2009), 1959 patients were identified from the clinical audit of cholecystectomies at North Shore and Waitakere hospitals, Auckland, New Zealand. There were two patients (0.1%) with DGB.

Patient 1, a 40-year-old female patient presented with a recurrent episode of biliary colic. During a previous hospital admission, a liver ultrasound scan was suggestive of DGB. Magnetic resonance cholangiopancreatography showed a DGB with two cystic ducts that enter the common bile duct (CBD) (Fig. 1). At laparoscopic cholecystectomy, it was possible to carry out a plane dissection between the two gallbladders up to the cystic duct of the smaller inferior DGB. Cholangiography via the inferior DGB Hartmann's pouch revealed that a cystic duct of the larger superior DGB joined the inferior DGB cystic duct at the confluence with the CBD. This confirmed that the patient had an embryological V-shaped split primordial DGB.² Both cystic ducts were doubly liga-clipped and endolooped together. After this, both gallbladders were removed.

Patient 2, an 81-year-old female patient with a history of open cholecystectomy 50 years ago had an elective open right hemicolectomy for a recurrent transverse colon mucinous adenocarcinoma, pT3c, N2, Mx. During the operation, a separate cystic duct stump entering the CBD and a 30 × 30 × 25 mm gallbladder located in the normal gallbladder fossa and containing a 15 × 10 × 8 mm stone were identified. The DGB had a cystic duct joining the common hepatic duct, embryologically a ductular accessory DGB.²