Early cholecystectomy for acute cholecystitis

Sir,

I read the article (early cholecystectomy for acute cholecystitis) by Mervat S. Al-Saleh et al, Saudi Medical Journal 1995; 16: 227-230. I do agree that early cholecystectomy is preferable for acute cholecystitis because it is more cost effective and carries no more mortality or morbidity than delayed cholecystectomy. However, I have my reservations on some points in the study: (i) the author said that the incidence of acute cholecystitis in Saudi Arabia is not less than the rest of the world. I think proof has to be provided in this case as we do not know what the incidence of gallstones or its complications are in Saudi Arabia; (ii) they did not put a criteria for diagnosing acute cholecystitis and one cannot depend on “provisional diagnosis” since it may vary from one to another; (iii) early cholecystectomy is defined as cholecystectomy carried out within 24-48 hours from the diagnosis of acute cholecystitis and not as a cholecystectomy which is carried out in the same admission. This is a rather important point because surgery carried out during the same admission can be due to acute complications of the disease, (empyema, gangrene, perforation) and this category is 61% in the study and not due to acute cholecystitis per se, 28% in the study. One cannot take an operation due to complications of acute cholecystitis as an argument for early cholecystectomy because the operation has to be carried out regardless and (iv) the author stated that “there was no advantage in delaying cholecystectomy over early operation in reducing the morbidity and mortality in a patient with a gangrenous gallbladder”. However, there were no patients of this kind in the delayed group and I do not think that any surgeon would like to leave a gangrenous gallbladder to late surgery! Finally, no statistical test of significance was carried out to compare the two groups (early and late) regarding the variables of mortality and morbidity.

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Rhinobisporidiosis in the Northern Region of Saudi Arabia

Sir,

Rhinobisporidiosis is a chronic fungal infection caused by rhinoisporidium seeberi. The disease is characterized by the development of friable vascular polyps, usually confined to the nose, mouth or eye but rarely seen on the genitalia or other mucous membranes. Rhinobisporidiosis is endemic in India and Sri Lanka. The disease is found with some frequency in the Chaco Valley of Argentina and in Brazil, Colombia and Venezuela. Data on approximately 40 cases have been published in the United States. A review of 23 cases from Europe revealed only 6 cases among native Europeans. Scattered cases occur throughout the world. It is rarely encountered in the Middle East or Saudi Arabia. We have encountered 3 cases of rhinoisporidiosis seen over a 9 year period in Arar Central Hospital Arar, Northern Region of Saudi Arabia which serves a population of about 100,000 residents in Arar and its suburbs. All three cases were Indian expatriates. Two patients had nasal polyps with epistaxis. Diagnosis by performing direct microscopic examination and histopathological examination is easy, which reveals characteristic sporangia with spores, one patient presented with conjunctival lesion. Rhinobisporidiosis is an endemic disease not encountered in Saudi Nationals. There is a constant increase in the number of expatriates from endemic areas working in Saudi Arabia. It is helpful to collect and report such pathologic entities that have occurred in non endemic areas so that appropriate preventive measures are taken to protect native population. The mode of infection of rhinoisporidiosis is not known, though infection is believed to originate from stagnant water or aquatic life. The following measures are suggested to prevent the spread of rhinoisporidiosis in Saudi Arabia. Medical examination should include screening for rhinoisporidiosis in those from endemic areas, before employing in water treatment plants, swimming pools, farms, agencies for water distribution, rain water collection and storage in cisterns, natural and manmade lakes. Strict supervision and periodic medical examination at 6 month intervals of the employees working in above places is to be advocated. A circular from Ministry of Health may be issued to all health units in the Kingdom enlightening the medical practitioners on the symptoms and signs of the disease. Hopefully these measures will ensure that the indigenous population remains free of the disease.

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