Quality of care is based on cycles of continuous improvement underpinned by three basic pillars: 1) structure: resources needed to meet material, human, financial and organisational objectives; 2) process: a series of interrelated tasks that together achieve the objectives; and 3) outcome: any change in health attributable to the process, and changes need to be measured by indicators based on scientific evidence[3].

The current Bullfighting Regulations lack guarantees when they state that for bullfighting events that are not first or second class, "an anaesthesiologist is not required", ignoring the high incidence of injuries in the rest (third class bullrings and popular festivals), regardless of the seriousness of the injuries[4].

Finally, we would like to leave a few questions unanswered because they are ambiguous: How is the inspection and enforcement function exercised? Which scientific societies have been involved in advising the responsible organisers? Who is responsible for the maintenance of the anaesthesia equipment? What are the quality and safety standards for performance and who monitors them?

There are many gaps to be filled and we must not look the other way. If we want to survive, we must get down to work.

REFERENCES

1. Ríos A. Cirugía Taurina en el siglo XXI. De la gloria al desprecio. Cir Esp. 2021;99:482–9. http://dx.doi.org/10.1016/j.ciresp.2020.12.014 [accessed 1 Nov 2021].
2. Gérvas J, Pérez-Fernández M. Cuando ya no puedes más: estructura, proceso y resultado. Acta Sanitaria.)2020;(Octubre) [accessed 1 Nov 2021]. Available from: https://www.actasanitaria.com/cuando-ya-no-puedes-mas-estructura-proceso-y-resultado/.
3. Saturno J, Gascón JJ, Parra P. Tratado de calidad asistencial en atención primaria. Tomo I. Madrid: Du Pont Pharma; 1997.
4. Real Decreto 1649/1997 por el que se regulan las instalaciones sanitarias y los servicios médico-quirúrgicos en los espectáculos taurinos [accessed 1 Nov 2021]. Available from: https://www.boe.es/eli/es/rd/1997/10/31/1649.

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Cholecystectomy and bariatric surgery in asymptomatic patients with cholelithiasis?☆

¿Colecistectomía y cirugía bariátrica en pacientes con colelitiasis asintomática?

Dear Editor,

The conclusions of the article published in your journal by Ainhoa Andrés-Imaz et al. on the appearance of cholelithiasis after bariatric surgery (BS)[1] recommend the postoperative use of ursodeoxycholic acid and concomitant cholecystectomy during bariatric surgery ''regardless of symptomatology''. I believe that following their study of de novo cholelithiasis occurring in 10% of patients during the first postoperative year of BS, further use of ursodeoxycholic acid would be justified, although controversial[2]. However, this finding may not be sufficient to promote cholecystectomy in all obese patients with cholelithiasis during BS.

For these patients, there is a clear consensus to perform cholecystectomy concomitant with BS when symptoms related to cholelithiasis are present[2–6], but in asymptomatic cases there are many doubts.

Firstly, the bariatric technique should be analysed, since performing cholecystectomy after vertical gastrectomy is not

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the same as after gastric bypass or another more complex technique[5]. There are articles that show a slight increase in complications in patients who undergo cholecystectomy after completing a gastric bypass[2,4,5]. However, other authors obtain good results and propose performing both techniques at the same time[6].

What happens in asymptomatic patients undergoing vertical gastrectomy? Vertical gastrectomy is a simpler procedure with a duration of about 60 min where cholecystectomy can increase the operation by 40–50 min. In this case, endoscopic access to the bile duct is still available and it is only the prevention of biliary complications together with the saving of a second operation that would support this double procedure.

In the SECO 2021 congress, we presented our experience in patients with symptomatic/asymptomatic cholelithiasis before BS and subsequent evolution with/without cholecystectomy. Of the 39 patients diagnosed with cholelithiasis by ultrasound over 10 years, the 10 symptomatic patients underwent surgery without incident, and vertical gastrectomy with cholecystectomy was successfully performed in 9 of the remaining 29. Most interestingly, 90% of the other 20 non-cholecystectomised patients remained asymptomatic for a long period of time (3–12 years).

To sum up, there are many factors to bear in mind when considering cholecystectomy during BS in asymptomatic patients with cholelithiasis. Perhaps the most important is the surgeons' experience in complex cholecystectomy[5]. If the team performs well and does not increase morbidity, cholecystectomy can be considered by mutual agreement with the patient. If not, the most sensible approach would be to perform the bariatric procedure and consider cholecystectomy when symptoms appear.

REFERENCES

1. Andrés-Imaz A, Martí-Gelonch L, Eizaguirre-Letamendia E, Asensio-Gallego JI, Enríquez-Navascués JM. Incidencia y factores de riesgo para el desarrollo de colelitiasis tras cirugía bariátrica. Cir Esp. 2021;99:648–54. http://dx.doi.org/10.1016/j.ciresp.2020.10.021.
2. Doulamis IP, Michalopoulos G, Boikou V, Schizas D, Spartalis E, Menenakos E, et al. Concomitant cholecystectomy during bariatric surgery: the jury is still out. Am J Surg. 2019;218:401–10. http://dx.doi.org/10.1016/j.amjsurg.2019.02.006.
3. O'Brien PE, Dixon JB. A rational approach to cholelithiasis in bariatric surgery. Arch Surg. 2003;138:908–12.
4. Hamad GG, Ikramuddin S, Gourash WF, Schauer PR. Elective cholecystectomy during laparoscopic Roux-En-Y gastric bypass: is it worth the wait? Obes Surg. 2003;13:76–81.
5. Warschkow R, Tarantino I, Ukegjini K, Beutner U, Güller U, Schmied BM, et al. Concomitant cholecystectomy during laparoscopic Roux-en-Y gastric bypass in obese patients is not justified: a meta-analysis. Obes Surg. 2013;23:397–407. http://dx.doi.org/10.1007/s11695-012-0852-4.
6. Kim JJ, Schirmer B. Safety and efficacy of simultaneous cholecystectomy at Roux-en-Y gastric bypass. SOARD. 2009;5:48–53. http://dx.doi.org/10.1016/j.soard.2008.06.001.

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