other hand, in the remaining cases in which there was no decrease in PTHio, a decrease in calcium and PTH was observed during follow-up, without requiring a second surgery.

Although our rate of non-lowering of iPTH was 5.5%, we found a cure rate of 97.5%. In the work of Laxague et al., this percentage is 4.2%, with a cure rate of 99%. The results of both series support the idea that, in cases where a single adenoma is suspected, PTHio measurement could be discontinued systematically, as recommended by the European Society of Endocrine Surgeons.[2] In these cases, in which there is concordance in imaging tests, the prevalence of multiglandular disease ranges between 1% and 3.5%[3], so we consider the benefit of iPTH to be very small.

In conclusion, according to our data, routine PTHio measurement is not necessary in patients with localised PTH. We encourage other groups to publish their experience both with the results of PTHio measurement and if they have discontinued it systematically.

## Conflict of interest

The authors have no conflict of interests to declare.

REFERENCES

1. Laxague F, Angeramo CA, Armella ED, Valinoti AC, Mezzadri NA, Fernández Vila JM. Preoperative matching studies in the diagnosis of parathyroid adenoma for primary hyperparathyroidism: Can we avoid intraoperative PTH monitoring? Cir Esp (Engl Ed). 2021 Oct;99:572–7.
2. Harrison BJ, Triponez F. Intraoperative adjuncts in surgery for primary hyperparathyroidism. Langenbecks Arch Surg. 2009;394:799–809.
3. Barczyński M, Gołkowski F, Nawrot I. The current status of intraoperative iPTH assay in surgery for primary hyperparathyroidism. Gland Surg. 2015;4:36–43.

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# Bullfighting surgery in the XXI century☆

## Cirugía taurina en el siglo XXI

With regard to the article by Dr. Ríos[1] in which he rightly reflects on the problems of bullfighting surgery, we would like to add other topics for concern that should be considered.

If this surgery is "always urgent" and "with a high volume of activity", and the primary objective pursued is to "save life" in situ, it is easy to understand that poor outcomes[2] are invariably the result, given the lack of experience and equipment.

The quality of care that is required must encompass the clinical safety it needs, although promotion of research in this particular scenario is lacking: it is necessary to measure in order to visualize. As drugs are studied, so too must we be aware of the efficacy and safety of the "bullring infirmaries", which are so unequal in infrastructures for dealing with the same task, and indeed we consider them the Achilles' heel of bullfighting.

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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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