

# Rethink Cholecystectomy During Bariatric Surgery

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SAN FRANCISCO — Relatively few patients benefit from routine cholecystectomy during laparoscopic or open gastric bypass surgery, according to results of two studies presented at the annual meeting of the American Society for Bariatric Surgery.

The new studies indicate that 10% or less of asymptomatic patients with negative findings during preoperative work-up will develop gallstones and even those with positive findings on ultrasound and CT scans or liver function tests have a low incidence of delayed cholecystectomy.

"We agree that any patient with acute or chronic cholecystitis would best benefit from a cholecystectomy, but our data [do] not support routine ultrasound or routine cholecystectomy in asymptomatic, morbidly obese patients considering weight loss surgery," said Dr. Dana D. Portenier of Duke University, Durham, N.C.

Routine cholecystectomy during open Roux-en-Y gastric bypass (RYGB) surgery was first recommended in 1985, and it is

**Cholecystectomy during bariatric surgery has been performed safely, but the procedure increases operative time and nearly doubles the length of hospital stay.**

commonly done because 10%-25% of patients undergoing this procedure develop gallstones.

Although ursodeoxycholic acid is sometimes used to decrease the incidence of post-RYGB cholelithiasis, this practice

has been criticized because of poor compliance and increased costs, Dr. Portenier said.

Cholecystectomy during laparoscopic RYGB has been performed safely, but the additional procedure increases operative time and nearly doubles the length of hospital stay (Obes. Surg. 2003;13:76-81).

Dr. Portenier and his colleagues reviewed the use of pre- or intraoperative ultrasound in 1,391 consecutive patients with abdominal complaints or elevated liver function tests who received RYGB during 2000-2005. Cholecystectomy was performed only in patients with biliary symptoms and positive findings on ultrasound. No patients received ursodeoxycholic acid postoperatively. Most patients (1,228) had laparoscopic operations.

The investigators excluded 334 patients (24%) from the study because they previously had a cholecystectomy.

The gallbladder was removed during RYGB in 17 of 541 patients who did not receive an ultrasound and in 27 of 406 patients who had a normal ultrasound. Most of these gallbladders were removed early in the series of patients during open RYGB, when it was the center's policy to perform routine cholecystectomy.

The gallbladder was removed at a later date in 29 (6%) of the remaining 524 patients who did not receive an ultrasound and in 37 (10%) of the remaining

379 patients who had a normal ultrasound.

Of the 110 patients with positive findings on ultrasound, 29 had their gallbladders removed during RYGB. Among the remaining 81 patients with positive findings on ultrasound, just 14 (17%) required a delayed cholecystectomy when they developed biliary symptoms.

All of the delayed cholecystectomies were performed between 1 and 30 months after RYGB, at an average of 11 months. The increased incidence of cholelithiasis

mainly occurs in the first 2 years after surgery and thereafter returns to baseline, Dr. Portenier said.

"Proponents of prophylactic cholecystectomy at the time of gastric bypass worry about gallstone pancreatitis, choledocholithiasis, and the unique problems they present in the Roux-en-Y gastric bypass," he said.

Of the 80 patients who required a delayed cholecystectomy, only 1 developed mild gallstone pancreatitis and none de-

veloped choledocholithiasis. One patient had a bile duct injury.

In a separate presentation, Dr. Scott J. Ellner reported on his center's experience with the use of a preoperative work-up to determine the need for a concomitant cholecystectomy during either RYGB or laparoscopic adjustable gastric banding (LAGB). The work-up includes abdominal ultrasound scanning, liver function tests, and a health history.

"Many patients are asymptomatic at the

Advertorial

## Helping "Cycle"

### Patients May Feel Trapped

For many patients with migraines, worrying may be a way of life. If they're not suffering through an attack, they may be worrying about when the next one might strike—possibly distracting them from the things that are most important to them.

Some patients may feel trapped in a seemingly endless cycle of suffering, treating and worrying. Many have found that acute migraine treatments alone are not enough. For these patients, the cycle starts with the migraine and continues *between attacks*. The sufferer treats one migraine and then worries that another one is coming soon. While the migraine attack itself can be disruptive, it can also affect them every day, even when they aren't having one.

**Patients who feel trapped may be more motivated to take daily preventive medication so they can have fewer migraines to worry about.** This type of migraine sufferer could be an active mother with several concerns:

- I can't afford to have my routine interrupted by frequent, disruptive migraines
- I have many responsibilities at work and home
- On any given day, I may be worried about when my next migraine might strike
- I'm not satisfied with my current acute therapies

TOPAMAX Tablets and TOPAMAX Sprinkle Capsules are indicated for adults for the prophylaxis of migraine headache. The usefulness of TOPAMAX in the acute treatment of migraine headache has not been studied.

TOPAMAX is contraindicated in patients with a history of hypersensitivity to any component of this product.

#### IMPORTANT SAFETY INFORMATION

TOPAMAX has been associated with serious adverse events, including:

Hyperchloremic, non-anion gap metabolic acidosis—lowering of bicarbonate levels in the blood. Measurement of baseline and periodic serum bicarbonate is recommended.

Acute myopia and secondary angle-closure glaucoma—patients should be cautioned to seek medical attention if they experience blurred vision or ocular pain.

Oligohidrosis and hyperthermia—decreased sweating and increased body temperature, especially in hot weather. The majority of reports have been in children.

time of preoperative work-up, despite having findings on ultrasound or abdominal CT scanning, and these patients also continue to be asymptomatic even after their weight loss surgery," said Dr. Ellner of the Center for Bariatric Surgery at St. Francis Hospital, Hartford, Conn.

Of 621 patients who underwent RYGB or LAGB at the center during 2003-2005, 451 had not undergone a previous cholecystectomy. After 4-25 months of follow-up, 29 (9%) of 332 patients who were originally asymptomatic and had a negative ultrasound scan at the time of the preoperative work-up developed symptoms of biliary disease. Similarly, of 102 patients

who were originally asymptomatic but had positive findings on ultrasound during the preoperative work-up, 9 (9%) later developed symptoms of biliary disease. A total of 17 patients who were symptomatic during the preoperative work-up had their gallbladders removed during bariatric surgery; most of these patients had open procedures, Dr. Ellner said.

None of the patients received ursodeoxycholic acid after surgery.

The percentage of patients who later required a delayed cholecystectomy changed to 10%-11% if the 98 patients who received LAGB were removed from the analysis. LAGB typically causes slower and

less weight loss than RYGB and would be expected to have a lower incidence of cholelithiasis than RYGB.

The patients who received LAGB had a shorter median time to cholecystectomy (4 months) than did those who received open (14 months) or laparoscopic RYGB (9 months), "which was somewhat perplexing and we're still trying to figure out why this is the case," Dr. Ellner said.

Nearly all of the delayed cholecystectomies (37 of 38) in Dr. Ellner's study were performed laparoscopically. Four patients had choledocholithiasis, and one had gallstone pancreatitis.

In both studies, the patients who partic-

ipated because they did not have a previous cholecystectomy may represent a pre-selected population with a lower risk for gallbladder pathology, the speakers noted.

The incidence of symptomatic biliary disease "will grow considerably" during the following decades from the 9% that was detected in the "very, very short follow-up" of Dr. Ellner's study, cautioned audience member Dr. Michael G. Sarr of the Mayo Clinic, Rochester, Minn. "That doesn't mean that we should be taking everyone's gallbladder out if you do [bariatric surgery] laparoscopically, but if you do [open surgery], I don't see any reason not to" take the gallbladder out. ■

Advertorial

# change the of Migraine"

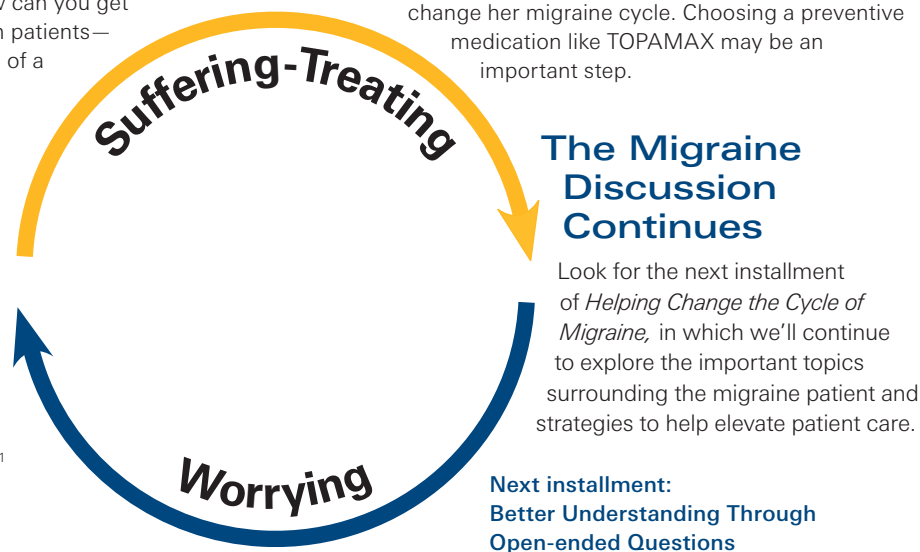
## Ask Her: Information is Key

Diagnosing the migraine cycle may depend on how well your patients communicate with you about how disruptive their migraine attacks are. How can you get more detailed information from patients—particularly within the confines of a busy, fast-paced practice?

Start by asking the right questions, for example—"How does migraine make you feel overall—even when you are not having one?" A recent linguistic study shows that by improving in-office communication, you can improve your assessment of the disability associated with migraine and make more appropriate treatment choices.<sup>1</sup>

## How Can You Help Change the Cycle?

Effectively reducing her migraine frequency can help change her migraine cycle. Choosing a preventive medication like TOPAMAX may be an important step.



  
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**TOPAMAX<sup>®</sup>**  
(topiramate) Tablets

Cognitive/psychiatric side effects, including cognitive dysfunction, psychiatric/behavioral disturbances, and somnolence and fatigue.

Most common adverse events associated with TOPAMAX 100 mg vs placebo were: paresthesia, 51% vs 6%; anorexia,\* 15% vs 6%; fatigue, 15% vs 11%; nausea, 13% vs 8%; diarrhea, 11% vs 4%; weight decrease, 9% vs 1%; taste alteration, 8% vs 1%.

The possibility of decreased contraceptive efficacy and increased breakthrough bleeding should be considered in patients taking combination oral contraceptive products with TOPAMAX.

Patients should be instructed to maintain an adequate fluid intake in order to minimize the risk of renal stone formation.

\*Anorexia is defined as loss of appetite.

**Please see brief summary of Prescribing Information on following page.**

**Reference:** 1. Hahn SR, Nelson M, Lipton RB. The language of migraine (LOM) study: frequency, impairment, and prevention in migraine communication. Poster presented at: Diamond Headache Clinic's 19th Annual Practicing Physician's Approach to the Difficult Headache Patient, February 14-18, 2006; Rancho Mirage, Calif.

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