LETTER TO THE EDITORS

Re: Xanthogranulomatous Cholecystitis: A Surgical Challenge
Published in QMJ, 2002;11 (1): 36-39.

Xanthogranulomatous Cholecystitis: A Surgical Challenge
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In this article\(^1\), the authors reviewed an interesting topic of which all Radiologists and Surgeons need to be aware. The pathology of the condition was well reviewed as well as the clinical presentation and the management in the four cases presented.

However, the following comments are noted:

1) The caption of Figure 2 mentions “pertubal duodenostomy”. This should read “pertubal duodenography” since this caption does not describe a surgical procedure “duodenostomy” but describes a radiographic examination injecting contrast through a tube inserted during the duodenostomy procedure.

2) The term “dye” has been used several times in the text to describe different types of contrast injected, e.g. Line 12 in the paragraph describing Case 7, in line 3 in the second paragraph describing Case 2 the caption for Figure 2 and in line 9 in the paragraph describing Case 4. Dye is a description of coloring material used to tinge or to impregnate tissue with color\(^1\). “Contrast medium” is the term used in radiology to describe different types of materials used to enhance visualization of anatomical details\(^2\).

3) Figure 2, 3 and 4 were used to described Case 2. It is traditional to use one figure number per case and label its figure as A, B, & C as long as they belong to only one patient\(^3\).

4) Caption of Figure 3 and 4 do not mention the type of examination performed. The captions on Figure 3 did not describe the radiological finding and the caption on both figures did not use arrows to demonstrate the findings.

5) The caption of most of the images is repeated within the text itself. This is against the instructions of most journals dealing with radiological images\(^4\).

6) In Figure 6, two black arrows are seen correctly pointing out to hypoechoic intramural fluid collections. However, a white arrow which is not described in the caption appears to point only to the bile within the gallbladder. In addition, there is a smaller white arrow on the left side of the image.

Again, this is not separately referred to in the caption is actually pointing out to a gallstone obstructing the gallbladder neck. The caption also describes “hypoechoic intramural shadows”. The term shadows in ultrasound are used to describe shadowing seen behind a sonographical reflectile area. A more accurate description should be multiple hypoechoic nodules.

7) In Figure 7, the caption does not mention the presence of arrows on the figure. However, multiple white arrows are seen pointing to the thickened ulcerated gallbladder wall with areas of fluid accumulation within. There is a black unlabelled arrow pointing to an area lateral to the head of the pancreas.

8) Although the title of the article is describing the xanthogranulomatous cholecystitis as a surgical challenge, very little surgical details and findings are mentioned in the discussion. Instead, the discussion is describing the pathology, the findings in the different imaging modalities and their differential diagnosis and how to reach a diagnosis preoperatively.

9) Fourth paragraph, p.3, second line, “high signal foci with signal ovoid” should read high signal foci with void lesions. This indicates areas with absent MR signal within.

10) Page 38, 3rd paragraph, line reads “CT scan maybe of significant help in perioperative differentiation”. CT scan is not use in these cases preoperatively, I suspect the author meant CT scan maybe of significant help in preoperative differentiation instead.

11) In Table 1, the authors mentions that no intramural hypovascular nodules are seen in gallbladder cancer. However, in a study comparing the CT scan findings in xanthogranulomatous cholecystitis and gallbladder carcinoma, these nodules are present in about 42% of gallbladder carcinoma\(^5\).

12) A question was posed at the end of the article “was is it possible to have an accurate preoperative diagnosis ...?”. The
answer was "yes". Such statements should be made with caution
since definitive preoperative radiological diagnosis is difficult
in most of the cases. At the moment accurate diagnosis remains
histopathological.

Thus, although the subject of the article was well chosen
with a series of interesting cases, lack of sufficient stress on
accuracy and details of the radiological images and findings
has undermined the value of this article. Clearly, including the
radiologist responsible for all or most of the numerous
radiological investigations utilized in the article could have
reduced the number of errors and enhanced the value of this
article.

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Authors’ Response . . .
to the letter of Dr. Hussein A. Kamel and Ahmed J. Omar

In response to the remarks which were given by Dr. Hussein
Kamel and Ahmed Omar from Radiology Department:

1) We value your interest in reading & evaluating our study
from radiological point of view. Your description of being a
well chosen and interesting topic is deeply appreciated.

2) We agree about trivial misdirected arrows in the captions
and their description, but it was always correctly highlighted
and described in the text.

3) We chose this rare topic, because as you see it was really
associated with significant and often catastrophic operative
complications. So, we tried to identify the subject and to increase
awareness of our surgeons. Moreover, to describe the pathology
and how to suspect it preoperatively?

4) The surgical details of the 4 patients was described and
nothing else was required in the discussion from that point of
view, because the aim of the study was not to describe the
operative technique, but to show how to diagnose them
beforehand to minimize complications.

5) This a descriptive case series study. So, we answer our
question depending on our findings, because it is nearly
impossible to do prospective randomized trial on such a rare
disease. The best available evidence in the literature is case
series studies.

6) We have included many X-ray captions to familiarize our
surgeons about the disease & to better describe the results for
each case. We agree if we have included a colleague Radiologist,
we would have avoided those term changes like “contrast” which
is the new name for the previously used “Dye”.

7) At the end we extend our thanks to all our Radiologists who
were involved in the imaging of these patients. We look forward
to perform combined studies in the future.

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