Sir,

I read with interest the article by Pawar et al in the recent issue of the journal. This article discusses about endoscopic management of bile leaks secondary to laparoscopic cholecystectomy and following percutaneous drainage of liver abscess.

There are a few points where more clarification was needed like opting for percutaneous transhepatic biliary drainage over endoscopic retrograde cholangiopancreatography (ERCP) in a case of ascites, where it is considered a relative contraindication.

Indication in six patients of percutaneous drainage of liver abscess needs further discussion as most the published studies have used the presence of jaundice and prolonged bile drainage as a threshold for ERCP as most of such cases resolve on their own.

Furthermore, the leaks in the cases of amoebic liver abscess (ALA) are usually from intrahepatic ductules, and the leaks, especially from the mid-common bile duct and common hepatic duct, need elucidation about the possible mechanism of injury.

In the three postcholecystectomy cases where no leak could be identified, the operators may have injected more dye after gaining access as therapy for narrowing, that is, dilatation could be performed in all the cases. If not, these cases should have been excluded from the final analysis of efficacy.

In a country with a huge load of ALA, a soft indication for ERCP in biliary leak may result in a large procedure burden with its antecedent cost and complications.

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Conflicts of Interest
None.

References
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