Gall Stone Dyspepsia

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One of the syndromes commonly encountered in the outpatient clinic is flatulent dyspepsia. By this we mean epigastric discomfort after meals, a feeling of fullness so that tight clothing is loosened, eructation with temporary relief, and regurgitation of sour fluid to the mouth with heartburn. The patient is usually a middle-aged obese woman. Radiological investigation may reveal gall stones, a hiatus hernia, a peptic ulcer, various combinations of these conditions, or nothing. We are particularly interested in the cases with gall stones. Are these cause or coincidence? When the patient asks, "If you take out my gall bladder, shall I lose my indigestion?" what is the surgeon to say?

Price (1963) investigated 142 women aged 50–70 in one general practice and found dyspepsia just as common in women with normal cholecystograms as in those with stones; he concluded that the dyspepsia was not due to the gall stones and should not influence the treatment. Smith and Sherlock (1964) claim that cholecystectomy gives excellent results unless the dyspepsia is really due to a duodenal ulcer, a hiatus hernia, diverticulitis coli, chronic constipation, overeating, or an unfaithful husband; since most of these patients at least overeat, this rather begs the question. According to Maingot (1956), cholecystectomy has little or no effect in curing the unpleasant symptoms of flatulent dyspepsia. Capper *et al.* (1967) provided an explanation for the dyspepsia associated with gall stones, and were promptly rebuked by French (1967) for perpetuating the myth that gall stones commonly cause flatulent dyspepsia.

Present Investigation

To attempt to answer this question we have reviewed patients who came to hospital with dyspepsia. They were placed in three groups: (1) those with gall stones who complained only of dyspepsia, (2) those with gall stones who had attacks of biliary colic as well as dyspepsia, and (3) those with dyspepsia but no radiological abnormality. Groups 1 and 2 had been treated by cholecystectomy, while group 3 had been treated only by reassurance and such symptomatic measures as their family doctors favoured. At least a year had elapsed since the operation, the patients being chosen from the records of 1958–65. Patients with peptic ulcers or stones in the common bile duct were excluded from the survey, but we included those with hiatus hernia. Since the operations were done by one of us (J. A. R.), the patients were interviewed (in 1967) by the other (L. W.).

At the interview the patient was asked how she had been since the operation and was led to speak of her indigestion. Then specific questions were put concerning the common symptoms of dyspepsia. Seventy-two patients with dyspepsia were asked to attend for review, but only 66 were seen. Four had left the district, one could not be traced, and one refused to attend—in the latter case we accepted her own doctor's opinion that the dyspepsia persisted unchanged. We do not feel that these absences invalidate our findings shown in the Table.

Summary of Findings

	Total	Cured	Improved	Unchanged
Cholecystectomy for dyspepsia ..	32	19	10	3
Cholecystectomy for biliary colic and dyspepsia	24	15	5	4
Radiologically negative dyspepsia	11	2	6	3

It will be seen that after cholecystectomy more than half the patients were completely free from dyspepsia and less than a quarter were unchanged. A history of attacks of biliary colic did not affect these proportions. The few males included in the survey did not have results that differed obviously from the females. The type of gall stone did not affect the result, nor did the impaction of a stone.

Ten cases had a hiatus hernia as well as gall stones; the results in these cases did not differ significantly from the rest. It was noted, however, that in the cases that were cured gastro-oesophageal reflux was not a prominent feature before operation; when it was a prominent feature in the preoperative symptoms it seldom improved. In contrast, several patients without a hiatus hernia had severe preoperative symptoms of gastro-oesophageal reflux and most of these were completely relieved of their symptoms after operation.

The mere passage of time does not cure flatulent dyspepsia, as is shown by our review of the patients with radiologically negative dyspepsia; only two of these patients were cured, and both ascribed their cure to the reassurance that there was nothing seriously wrong. After cholecystectomy the patients who were not improved usually complained in the early postoperative period; the others did not show a tendency to relapse after the psychotherapeutic effect of an operation might be expected to diminish.

Summary

Cholecystectomy for gall stones cures flatulent dyspepsia in more than half the cases, and less than a quarter are not improved. The presence of a hiatus hernia does not lessen the probability of cure unless the dominant symptoms indicate gastro-oesophageal reflux.

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