

Cholecystectomy for Gallstones

Scope

This policy covers Cholecystectomy for the management of patients with asymptomatic and symptomatic gallstones. It does not cover surgery related to malignancy or trauma.

Definitions

Cholecystectomy: removal of the gallbladder including open, laparoscopic, mini-laparoscopic and needlescopic cholecystectomy.

Asymptomatic gallstones: the presence of gallstones detected incidentally in patients who do not have any abdominal symptoms or have symptoms that are not thought to be due to gallstones. Diagnosis is made during routine ultrasound for other abdominal conditions or, occasionally, by palpation of the gallbladder at operation.

Symptomatic gallstones: associated with inflammation of the gallbladder (Cholecystitis), bile duct (Cholangitis), pancreas (pancreatitis), biliary colic or obstructive jaundice.

Policy

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the [referral proforma](#).

The CCG will fund Cholecystectomy for **symptomatic gallstones** with episodes of:

- acute cholecystitis or cholangitis; **OR**
- biliary colic; **OR**
- gallstone induced pancreatitis; **OR**
- obstructive jaundice due to gallstones.

The CCG will fund Cholecystectomy for patients with symptomatic or asymptomatic **common bile duct stones**.

Surgery for **asymptomatic gallstones** is a lower clinical priority and will only be funded after prior approval by the Exceptional Cases Panel.

For patients meeting the criteria for day-case surgery, only day-case surgery will be funded.

Note: Patients who smoke should be advised to attempt to stop smoking and referred to stop-smoking services – see [stop smoking policy](#)

Rationale and Evidence

In people with asymptomatic gallstones, rates of complication (acute pancreatitis, obstructive jaundice, cholecystitis) are low, ranging from 1-2% per year¹ and NICE² does not recommend prophylactic cholecystectomy in patients with asymptomatic gallstones as the risks of surgical intervention outweigh the perceived benefits. For patients with symptomatic gallstones, early intervention with cholecystectomy is likely to be appropriate as many will re-present with complications³⁻⁵ and NICE recommend early cholecystectomy in patients with symptomatic gallstones.² For patients with bile duct stones, a high proportion become symptomatic and require subsequent cholecystectomy⁶ and NICE recommend cholecystectomy in symptomatic and asymptomatic patients where stones have migrated into the common bile duct.² Evidence does not show a benefit on patient outcomes (rate of readmission, time to return to work, etc) for over-night stay compared with day surgery⁷ and, where there are no specific patient risks, day surgery should be done.

Estimated number of people affected

Approximately 15% of adults may have gallstone disease, and most of these people do not have symptoms.² The development of gallstones is associated with obesity and weight loss. Overall the prevalence in women is twice that in men and the prevalence rises with age.

References

1. Friedman G, Raviola C & Fireman B. Prognosis of gallstones with mild or no symptoms: 25 years of follow-up in a health maintenance organization. *J Clin Epidemiol.* 42, 127–36 (1989).
2. National Institute for Health and Care Excellence CG188. Gallstone disease: diagnosis and management. (2014).
3. van Baal M C, et al. Timing of Cholecystectomy After Mild Biliary Pancreatitis. *Ann. Surg.* 255, 860–866 (2012).
4. da Costa D, et al. Same-admission versus interval cholecystectomy for mild gallstone pancreatitis (PONCHO): a multicentre randomised controlled trial. *Lancet* 386, 1261–8 (2015).
5. Jee, S. L., Jarmin, R., Lim, K. F. & Raman, K. Outcomes of early versus delayed cholecystectomy in patients with mild to moderate acute biliary pancreatitis: A randomized prospective study. *Asian J. Surg.* 41, 47–54 (2018).
6. Khan, M. et al. Role of Cholecystectomy After Endoscopic Sphincterotomy in the Management of Choledocholithiasis in High-risk Patients: A Systematic Review and Meta-Analysis. *J Clin Gastroenterol.* 52, 579–589 (2018).
7. Vaughan J, Gurusamy K S, Davidson B R. Day-surgery versus overnight stay surgery for laparoscopic cholecystectomy. *Cochrane Database of Systematic Reviews* 2013, Issue 7. Art. No.: CD006798.

Glossary

Cholangitis:	Inflammation of the bile duct.
Cholecystitis:	Inflammation of the gall bladder.
Choledocholithiasis:	Gall stones in the bile duct.
Cholelithiasis:	Gall stones.
Obstructive Jaundice:	Jaundice due to obstruction of the bile duct.
Pancreatitis:	Inflammation of the Pancreas.

Policy effective from:	In line with IPAC terms of reference GB to acknowledge 3 March 2020 Reviewed policy approved by IPAC 28 January 2020 Reviewed policy approved by CPF 11 November 2019 February 2020
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