NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Policy title	**Cholecystectomy for gallbladder stones, common bile duct stones and biliary dyskinesia** **V3.0**
Policy position	**Criteria Based Access**
Date of ICB recommendation	**November 2023**

Gallbladder stones

- Reassure people with asymptomatic gallbladder stones found in a normal gallbladder and normal biliary tree that they do not need treatment unless they develop symptoms, however prophylactic cholecystectomy for patients with silent (asymptomatic) gallstones may be appropriate in specific patients. See prophylactic cholecystectomy below.
- Patients with an incidental finding of stones in an otherwise normal gallbladder and biliary tree require no further investigation or referral; asymptomatic patients should not be referred to secondary care.
- Laparoscopic cholecystectomy will be funded for people diagnosed with symptomatic gallbladder stones. The decision to operate should be made by the patient with guidance from the surgeon. This will include assessment of the risk of recurrent symptoms and complications of the gallstones and the risks and complication rates of surgery in relation to the individual patient's co-morbidities and preference.
- For patients having an elective planned procedure, offer day-case laparoscopic cholecystectomy unless their circumstances or clinical condition make an inpatient stay necessary.

Biliary Dyskinesia

- Biliary dyskinesia may be appropriate for patients experiencing right upper quadrant pain. Patients should have a positive hepatobiliary iminodiacetic acid (HIDA) scan and other causes of biliary pain should be excluded before a cholecystectomy is considered.

Common bile duct (CBD) stones

- Bile duct clearance and laparoscopic cholecystectomy will be funded for people with symptomatic or asymptomatic common bile duct stones.

Timing of surgery following acute admission

- For patients who are admitted to hospital with acute cholecystitis or mild gallstone pancreatitis, index laparoscopic cholecystectomy should be performed within that admission. These patients should have their gallbladders removed, ideally before discharge, to avoid further delay and prevent further potentially fatal attacks. If the patient is fit enough for surgery and same admission cholecystectomy will be delayed for more than 24 hours, it may be

reasonable to make use of a virtual ward, where the patient can return home under close monitoring prior to undergoing surgery as soon as possible.

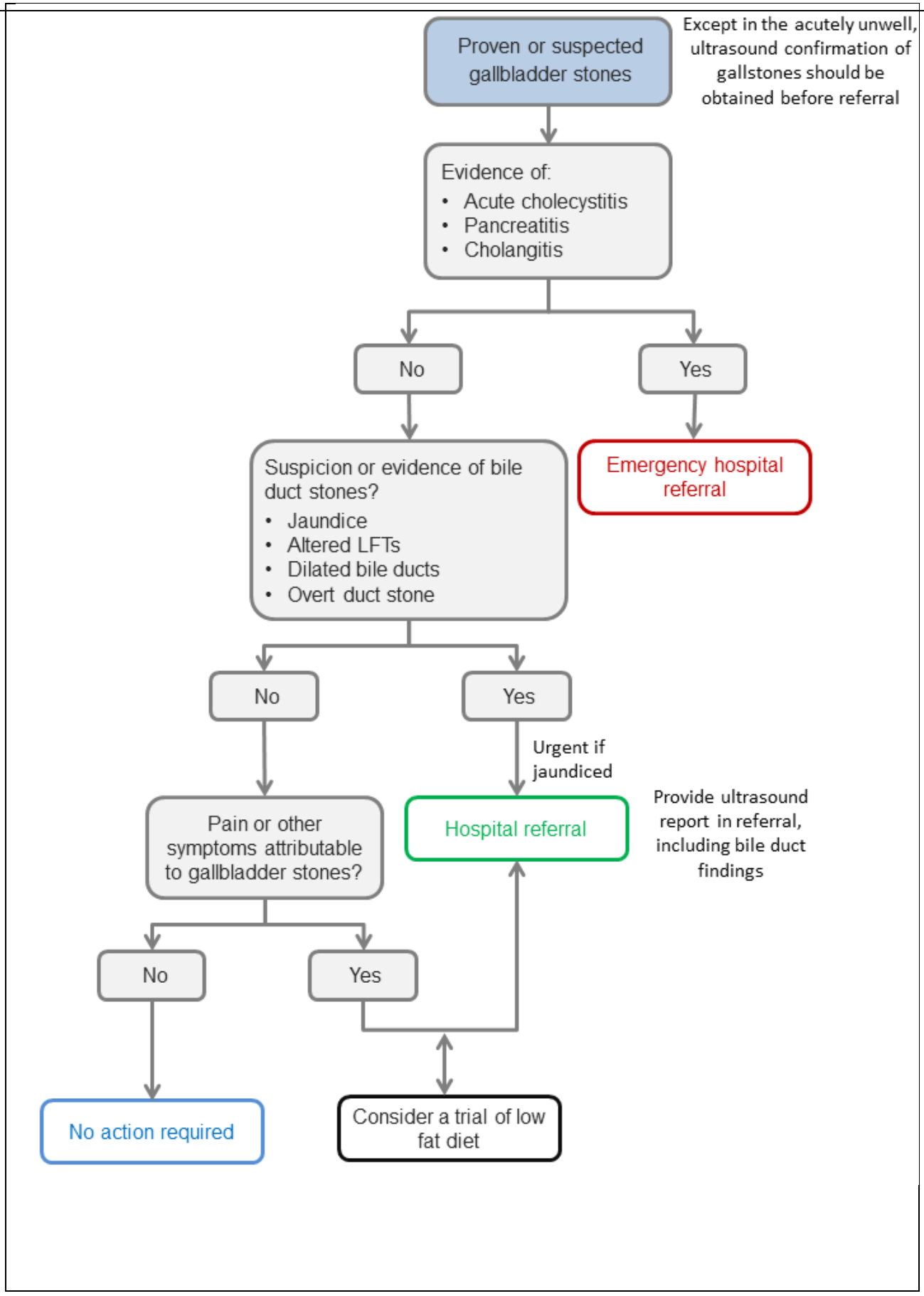
- Otherwise patients diagnosed with acute cholecystitis should have their laparoscopic cholecystectomy on the same admission within 72 hours (NICE guidelines published in October 2014 state one week, but 72 hours is preferable). This guidance may not be applicable in patients with severe acute pancreatitis.
- Surgery for these patients may be challenging and can be associated with a higher incidence of complications (particularly beyond 96 hours) and a higher conversion rate from laparoscopic surgery to open surgery. These patients should be operated on by surgeons with experience of operating on patients with acute cholecystitis, or if not available locally, transfer to a specialist unit should be considered. Timely intervention is preferable to a delayed procedure, and, if the operation cannot be performed during the index admission it should be performed within two weeks of discharge.

Prophylactic cholecystectomy

Prophylactic cholecystectomy for patients with silent (asymptomatic) gallstones may be appropriate if the patient meets at least one of the criteria below, taking into account and the risks and complication rates of surgery in relation to the individual patient's co-morbidities and preference.

1. Clear evidence of being at risk of gallbladder carcinoma:
   a. With family history of gallbladder carcinoma,
   b. With single solitary gallstone of > 3 cm size.
   c. With porcelain gallbladder.
   d. Gallbladder polyps > 10 mm size, patients with smaller sized polyps and no gallstones may also be appropriate depending on other risk factors.
2. Sickle cell disease or other chronic haemolytic disease
3. Immunocompromised or transplant recipient
4. Patient is undergoing abdominal surgery for other indications (e.g. cirrhosis of the liver or other gastro-intestinal indications)

- Please note the Evidence Based Interventions recommendation regarding Early endoscopic retrograde cholangiopancreatography (ERCP) for acute gallstone pancreatitis without cholangitis if relevant.
- Please see Royal College of Surgeons Commissioning Guide Flowchart below for further information


Proven or suspected gallbladder stones
Except in the acutely unwell, ultrasound confirmation of gallstones should be obtained before referral
Evidence of:
• Acute cholecystitis
• Pancreatitis
• Cholangitis
No
Yes
Emergency hospital referral
Suspicion or evidence of bile duct stones?
• Jaundice
• Altered LFTs
• Dilated bile ducts
• Overt duct stone
No
Yes
Urgent if jaundiced
Hospital referral
Provide ultrasound report in referral, including bile duct findings
Pain or other symptoms attributable to gallbladder stones?
No
Yes
No action required
Consider a trial of low fat diet

References

1. NICE, Gallstone disease: diagnosis and management: Clinical guideline [CG188], 2014. Available at: https://www.nice.org.uk/guidance/cg188/evidence/full-guideline-pdf193302253
2. Academy of Medical Royal Colleges. Cholecystectomy, 2020. Available at: https://www.aomrc.org.uk/ebi/clinicians/cholecystectomy/
3. World Gastroenterology Organisation Practice Guideline. Available at: http://www.worldgastroenterology.org/assets/downloads/en/pdf/guidelines/10_gallstone_en.pdf
4. Gurusamy KS, Samraj K. Cholecystectomy for patients with silent gallstones. Cochrane Database of Systematic Reviews 2007, Issue 1. Available at: https://www.cochrane.org/CD006230/LIVER_no-evidence-to-assess-surgical-treatment-inasymptomatic-gallstones
5. Royal College of Surgeons. Commissioning Guide: Gallstone Disease, 2016. Available at: https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/gallstone-disease-commissioning-guide-for-republication.pdf

NOTE:

- This policy will be reviewed in the light of new evidence or new national guidance e.g. from NICE
- Where a patient does not meet the policy criteria or the intervention is not normally funded by the NHS, an application for clinical exceptionality can be considered via the ICB's Individual Funding Request (IFR) Policy and Process

Clinical coding:

Age range: ALL

Cholecystectomy OPCS Procedure Codes

J181 Total cholecystectomy and excision of surrounding tissue,
J182 Total cholecystectomy and exploration of common bile duct,
J183 Total cholecystectomy NEC,
J184 Partial cholecystectomy and exploration of common bile duct,
J185 Partial cholecystectomy NEC,
J188 Other specified excision of gall bladder
J189 Unspecified excision of gall bladder
J211 Open removal of calculus from gall bladder
J212 Drainage of gall bladder – Includes Cholecystectomy NEC

Not Normally Funded - ICD10 Diagnosis Codes:

K802 Calculus of gallbladder without cholecystitis
K805 Calculus of bile duct without Cholangitis or cholecystitis
K808 Other cholelithiasis

Criteria-Based Access – ICD10 Diagnosis Codes:

K800 Calculus of gallbladder with acute cholecystitis
K801 Calculus of gallbladder with other cholecystitis
K803 Calculus of bile duct with cholangitis
K804 Calculus of bile duct with cholecystitis
K810 Acute cholecystitis
K828 Other specified diseases of gallbladder (for biliary dyskinesia)
K831 Obstruction of bile duct (obstructive jaundice)
K850 Idiopathic acute pancreatitis
K851 Biliary acute pancreatitis
K852 Alcohol-induced acute pancreatitis
K853 Drug-induced acute pancreatitis
K854 Other acute pancreatitis
K855 Acute pancreatitis, unspecified

Global cancer exclusion - **C[0-9][0-9]%, D0%, D3[789]%, D4[012345678]%**

For prophylactic gallbladder removal:
Z809 Family history of malignant neoplasm of gastrointestinal tract
D571 Sickle-cell anaemia without crisis [includes sickle-cell disease]
D899 Disorder involving the immune mechanism, unspecified
K746 Other and unspecified cirrhosis of liver
K703 Alcoholic cirrhosis of liver

Policy update record	
November 2023 BLMK ICB QP meeting v3.0	Policy updated to include criteria concerning Biliary dyskinesia Criteria separated out into sections, i.e. Gallbladder stones, Bile duct stones Royal College of Surgeon flowchart added Reworded direction to prophylactic cholecystectomy Update/check Clinical Coding

Key words: Cholecystectomy, gallbladder stones, bile duct stones, biliary dyskinesia