Derby and Derbyshire
Clinical Commissioning Group

CLINICAL POLICY ADVISORY GROUP (CPAG)

Cholecystectomy Policy

Statement

Derby and Derbyshire CCG (DDCCG), in line with its principles for procedures of limited clinical value, has deemed that the referral for assessment and treatment of symptomatic gallbladder stones should not routinely be commissioned unless one or more of the following criteria is met:

- Patients with clinically significant symptomatic gallstones (typically epigastric or right upper quadrant pain, frequently radiating to the back, lasting for several minutes to hours, often occurring at night)
- Confirmed episode via clinical diagnosis of cholecystitis
- Confirmed episode of obstructive jaundice caused by biliary calculi
- Confirmed episode of gall stone induced pancreatitis
- Where there is clear evidence from an ultrasound scan that the patient is at risk of gallbladder carcinoma
- Gallstones that are obstructing the flow of bile for long periods of time or move into other organs i.e. pancreas, small bowel etc.
- Patient has diabetes mellitus, is a transplant recipient or has cirrhosis, and has been managed conservatively but subsequently develops symptoms which cause significant functional impairment

DDCCG do not commission the removal of the gallbladder for asymptomatic gall bladder stones

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the CCG.

1. Background

Gallstones are crystalline fatty or mineral deposits that form in the gallbladder and affects between 5-25% of adults in the western world. Gallstones are associated with a higher prevalence in women and the older age group.

Most people (80%) with gallstones are asymptomatic. In a small proportion of people gallstones can irritate the gallbladder or block part of the biliary system resulting in pain, infection and inflammation. These symptoms can eventually lead to cholecystitis, cholangitis, and pancreatitis and jaundice if left untreated.

Cholecystectomy is the surgical removal of the gallbladder. The main two types of cholecystectomy are laparoscopic cholecystectomy and open cholecystectomy, both of which are carried out under general anaesthetic.

2. Recommendation

Derby and Derbyshire CCG (DDCCG) does not routinely commission the referral for assessment and treatment of symptomatic gallbladder stones unless one or more of the following criteria is met:

- Patients with clinically significant symptomatic gallstones (typically epigastric or right upper quadrant pain, frequently radiating to the back, lasting for several minutes to hours, often occurring at night).
- Confirmed episode via clinical diagnosis of cholecystitis
- Confirmed episode of obstructive jaundice caused by biliary calculi
- Confirmed episode of gall stone induced pancreatitis
- Where there is clear evidence from an ultrasound scan that the patient is at risk of gallbladder carcinoma
- Gallstones that are obstructing the flow of bile for long periods of time or move into other organs i.e. pancreas, small bowel etc.
- Patient has diabetes mellitus, is a transplant recipient or has cirrhosis, and has been managed conservatively but subsequently develops symptoms which cause significant functional impairment

NB. Criteria must be met prior to referral for elective referrals.

Exceptions to the Policy
There are no restrictions applied to patients with symptomatic gall bladder stones or symptomatic/asymptomatic patients with common bile duct stones.

Exclusion Criteria
DDCCG do not commission the removal of the gallbladder for asymptomatic gall bladder stones. Asymptomatic gallstones are gallstones found incidentally when having an ultrasound for another reason unconnected to gallstone disease and in patients who have been symptom free for at least 12 months.

3. Rationale for Recommendation

The NICE Clinical Guideline (CG188) (2014) on gallstone disease recommends that only symptomatic gallstones should be treated with laparoscopic cholecystectomy. This is because prophylactic treatments aimed at preventing future complications are not recommended (such as prophylactic cholecystectomy) as the risk of complications from surgical treatment outweighs the potential risk of developing complications from the stones. Such complications include infection, bile leaks, bile duct injury, bleeding, intestine injury, post-cholecystectomy syndrome and deep vein thrombosis. The procedure also carries risks from having a general anaesthetic. Furthermore, 20% of the adult population has asymptomatic gallstones and 70% of these will never have a clinical event. The incidence of developing symptoms is 2-4% per annum.

4. Useful Resources

- Gallbladder Removal, NHS, last reviewed December 2018, https://www.nhs.uk/conditions/gallbladder-removal/

5. References

- Gallstone Disease: Diagnosis and Management, NICE CG188, published October 2014, accessed 16/03/2020, https://www.nice.org.uk/guidance/cg188/resources/gallstone-disease-diagnosis-and-management-pdf-35109819418309
- Gallstones, NICE Clinical Knowledge Summaries, updated June 2019, accessed 16/03/20, https://cks.nice.org.uk/gallstones#!scenario
- Gurusamy Kurinchi S, Davidson Brian R. Gallstones BMJ 2014; 348 :g2669, https://www.bmj.com/content/348/bmj.g2669

6. Appendices

Appendix 1- Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Clinical Policy Advisory Group	December 2020
Clinical and Lay Commissioning Committee	January 2020
Consultant General Surgeon, UHDBFT	March 2020
Consultant General Surgeon, CRHFT	March 2020
Clinical Policy Advisory Group	June 2020
Clinical and Lay Commissioning Group	July 2020

Appendix 2- Document Update

Document Update	Date Updated
Version 3 - Criteria added for funding including bile duct stones under asymptomatic gallstones	April 2017
Version 3.1 - For elective referrals, criteria must be met prior to referral, remove 5 hour pain duration replace with Epigastric or right upper quadrant pain, frequently radiating to the back, lasting for several minutes to hours (often occurring at night).	July 2017
Version 3.2 - Update to funding statement and additional wording within secondary care criteria. Wording removed from not routinely commissioned pages in the policy.	November 2017
Version 3.3 - Addition of 'This procedure requires prior approval. Prior approval must be sought through Blueteq.' as requested by contracting.	October 2019
Version 3.4 – Removal of prior approval and related information on policy, including the statement 'Patients may also present acutely in these cases, secondary care may seek prior approval'.	January 2020
Version 4 – Policy re-worded and reformatted to reflect the new organisation; addition of background information, rationale for recommendation, useful resources and references.	April-June 2020

Appendix 3 - OPCS code(s)

J18, J181, J182, J183, J184, J185, J188, J189, J21, J211, J212, J213, J218, J219