NHS
Derby and Derbyshire
Integrated Care Board

CLINICAL POLICY ADVISORY GROUP (CPAG)

Cholecystectomy for Symptomatic Gallbladder Stones Policy

Statement

NHS Derby and Derbyshire ICB (NHSDDICB), 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

NHSDDICB 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 ICB.

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

NHS Derby and Derbyshire ICB (NHSDDICB) 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 gallbladder stones or symptomatic/asymptomatic patients with common bile duct stones.

Exclusion Criteria
NHSDDICB 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 Gallstone disease: diagnosis and management CG188 (2014) 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. Shared Decision-Making

Shared decision-making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

Decision support tools, also called patient decision aids, support shared decision making by making treatment, care and support options explicit. They provide evidence-based information about the associated benefits/harms and help patients to consider what matters most to them in relation to the possible outcomes, including doing nothing.

5. Useful Resources

- Gallbladder Removal, NHS, last reviewed December 2018, https://www.nhs.uk/conditions/gallbladder-removal/
- NHS England » Decision support tool: making a decision about gallstones

6. References

- Gallstone Disease: Diagnosis and Management, NICE CG188, published October 2014, accessed 30/03/23, https://www.nice.org.uk/guidance/cg188/resources/gallstone-disease-diagnosis-and-management-pdf-35109819418309
- Gallstones, NICE Clinical Knowledge Summaries, updated June 2019, accessed 30/03/23, 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

7. 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**
Consultant Pancreaticobiliary, Obesity, Laparoscopic and Robotic Surgeon Clinical Lead for Upper GI Surgery, UHDBFT	April 2023
Consultant Upper GI surgeon, UHDBFT	April 2023
Consultant General and Colorectal Surgeon, Assistant Clinical Director for General Surgery, QHBFT	March 2023
Consultant General Surgeon, QHBFT	April 2023
Consultant General Surgeon, QHBFT	April 2023
Consultant General, Upper GI and Laparoscopic Surgeon, CRHFT	April 2023
Upper GI surgeon, CRHFT	April 2023
Consultant Colorectal surgeon, CRHFT	April 2023
Clinical Policy Advisory Group (CPAG)	April 2023

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 5.0 • Policy re-worded to reflect the new NHSDDICB organisation	April 2023
Version 5.1 • Reference to shared decision making added	September 2024

Appendix 3 - OPCS code(s)

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