Biliary Pathology

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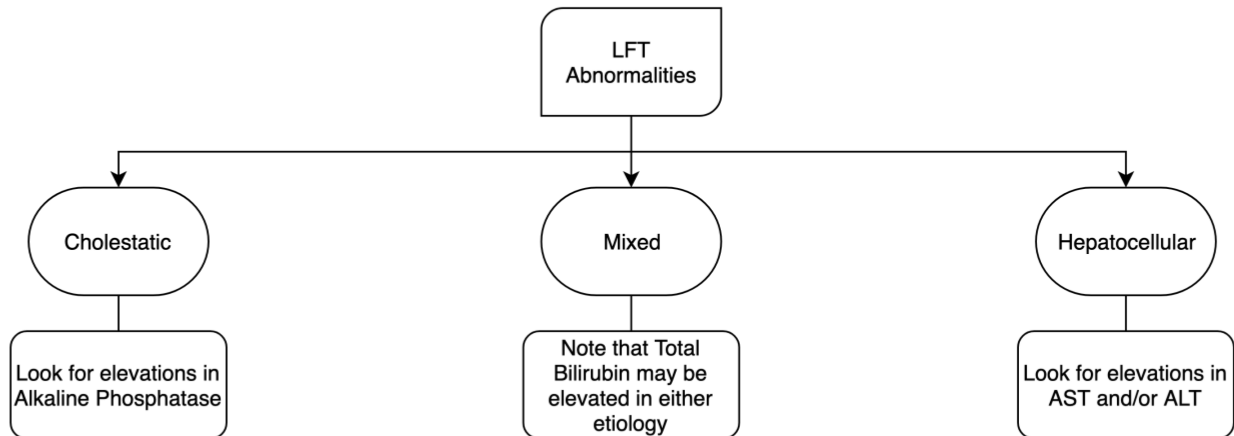

I. DDx based on Anatomy: Patient w/ fever, RUQ abdominal pain, + Murphy's sign
- **Symptomatic cholelithiasis (biliary colic**): stone transiently obstructing the cystic duct
- **Acute cholecystitis**
    - stone impacted in cystic duct
    - acalculous (~10% of cases, usually critically ill patients)
- **Choledocholithiasis:** stone in common bile duct (CBD). Very strong predictors of CBD stone (any of the following):
    - Visualize CBD stone on ultrasound
    - Presenting with ascending cholangitis
    - Total Bilirubin > 4
- **Ascending cholangitis: emergency**. Think Charcot's Triad (RUQ pain, fever, jaundice) and Reynold's Pentad (Charcot's + altered mental status and hypotension).

II. Initial Management:
- *Labs*: CBC, LFTs, *Imaging*: RUQ abdominal ultrasound
- **Symptomatic cholelithiasis:** cholecystectomy in the outpatient setting
- **Acute cholecystitis:**
    - Cover gram negative rods & anaerobes (empiric antibiotics, example: Pip-tazo, cipro+metronidazole).
    - Keep antibiotics going until source control is achieved (cholecystectomy)
    - Cholecystostomy tube (by IR) used if patient is not a surgical candidate
    - Extend antibiotic course if patient has documented bacteremia
- **Choledocholithiasis:** ERCP to remove CBD stone followed by cholecystectomy
- **Ascending cholangitis:** emergent ERCP, IV antibiotics, IV fluids → cholecystectomy
- Consultants:
    - Surgeons should be involved in all cases
    - GI when there is concern for CBD stone