Gallstones

GP Assessment
1. **History** - RUQ abdominal pain, often radiating to back. Post-prandial attacks of pain lasting a few hours.
2. **Examination** - RUQ pain on palpation, (Murphy’s sign), evidence of sepsis, jaundice.
3. **Investigations** - FBC, CRP, UEs, LFTs, Lipase, USS abdomen should be arranged

ASYMPTOMATIC PATIENT
(gallstones found on incidentally on USS or other imaging)

- Reassure patient
- No further action is required

Evidence of Gallstones on USS
- No evidence of bile duct stones on USS, LFTS or clinically
  - Still symptomatic with abdominal pain
- Evidence of bile duct stones present on USS, LFTS or clinically e.g;
  - dilated bile ducts
  - overt duct stone
  - altered LFTs
  - jaundice

Management in the community (adequate for up to 30% of patients)
- Analgesia
- Low fat diet
- No role for medical treatment, including hyoscine or proton pump inhibitors
- Antibiotics should be reserved for patients with signs of sepsis
- No role for shockwave treatment
- Review in 1-3 months

Resolution of symptoms or satisfactory improvement
Symptoms not improved satisfactorily

Referral to general surgery.
Refer urgently if jaundiced.
- St George’s Hospital (e-RS)
- St Helier Hospital (e-RS)
- LFTs should be monitored in community until definitive treatment
- Patient will require lap cholecystectomy and bile duct clearance as per hospital protocols
- Ensure results of imaging and bloods included in referral

High Risk
History and examination suggestive of an acutely unwell patient, signs of sepsis or bloods results suggesting:
- Cholangitis
- Pancreatitis
- Acute cholecystitis

Susicion of upper GI malignancy on USS or any red flags
- URGENT SUSPECTED CANCER REFERRAL (link to 2WW upper GI form)

Arrange for immediate hospital transfer

Patient information leaflets:
- PatientUK - Gallstones
- PatientUK - Gallstones diet sheet
- PatientUK - Cholecystitis

References:
1. NICE Clinical Guidelines. Gallstones Diagnosis and Management
2. Royal College of Surgeons. Gallstones Disease

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