Draft General Commissioning Policy

Treatment	Cholecystectomy
For the treatment of	Cholecystectomy for Gallstones
Background	This commissioning policy is needed in order to clarify the threshold for surgical treatment of gallstones, to reduce variation in practice across the region.
Commissioning position	NHS Hull CCG has previously included 'cholecystectomy for gallstones' on the list of procedures that are NOT normally commissioned other than in exceptional circumstances i.e. via the Individual Funding Request Panel (IFR). Elective referral into secondary care for a cholecystectomy assessment will now only be commissioned if the patient fulfils ANY of the criteria below: ● Symptomatic gallstones with a thickened gallbladder wall ● A dilated common bile duct on ultrasound ● Asymptomatic gallstones with abnormal liver function test (LFT) results ● Asymptomatic gall bladder polyp(s) reported on ultrasound ● Symptomatic gall bladder 'sludge' reported on ultrasound Elective cholecystectomy surgery will only be commissioned where the patient fulfils ANY of the criteria below: ● Symptomatic gallstones ● Gall bladder polyp(s) larger than 8mm or growing rapidly ● Common bile duct stones ● Acute pancreatitis Documentation that the threshold criteria are fulfilled is mandatory and the referral letter or form should, as a minimum, contain a clear indication of the grounds for referral against the threshold criteria; ● any relevant medical history and current medication; ● any known factors affecting the patients fitness for day surgery; ● a recent ultrasound report conducted within 2 months at the point of referral; ● recent liver function test report conducted within 1 month at point of referral. Cholecystectomy should be performed laparoscopically in patients with an uncomplicated abdomen and in the absence of contra-indications. (The standard laparoscopic approach uses several small incisions in the abdomen). Cholecystectomy should be offered as a day case procedure in the absence of contra-indications. Routine laparoscopic cholecystectomy does not generally require a consultant outpatient follow up. If the gall bladder is sent for histological examination, the results should be reviewed by the requesting consultant and communicated to the GP.

	Secondary providers offering cholecystectomy must be able to offer intraoperative on-table cholangiography and have arrangements in place for urgent access to ERCP and interventional radiology for the management of postoperative complications.
Effective from	October 2015
Summary of evidence / rationale	Cholecystectomy is the surgical removal of the gall bladder. Prophylactic Cholecystectomy is not indicated in most patients with asymptomatic gallstones. Possible exceptions include patients who are at increased risk for gallbladder carcinoma or gallstone complications, in which prophylactic Cholecystectomy or incidental Cholecystectomy at the time of another abdominal operation can be considered. Although patients with diabetes mellitus may have an increased risk of complications, the magnitude of the risk does not warrant prophylactic Cholecystectomy. Primary and secondary care discussions with patients should include identifying options (surgery vs no surgery), including the risks and benefits of each.
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3. **British Society of Gastroenterology (July 2008) Guidelines on the management of common bile duct stones** http://www.bsg.org.uk/pdf_word_docs/cbds_08.pdf

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