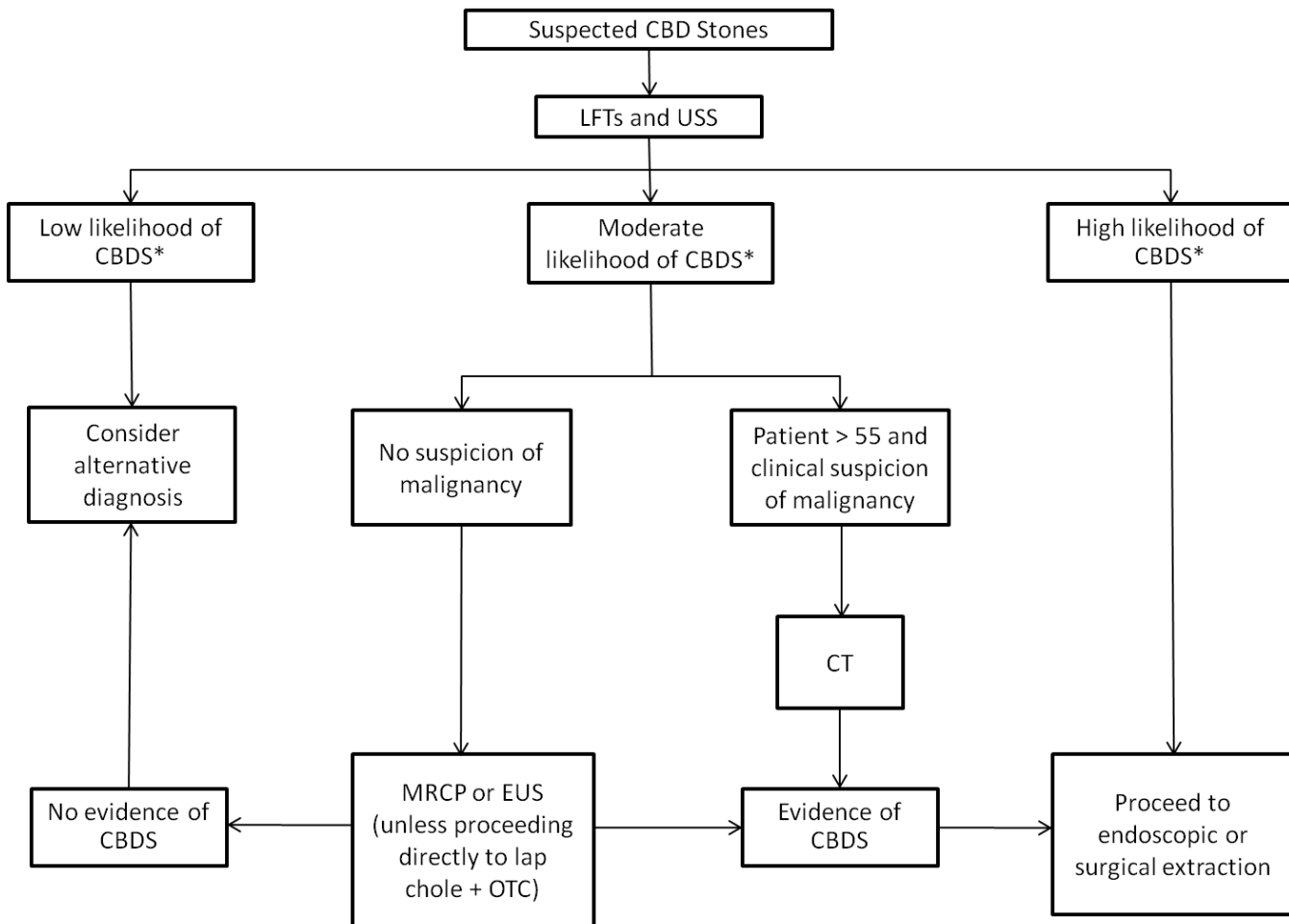


**Management of Common Bile Duct (CBD) Stones and ERCP/ PTC  
 Preparation - Summary Clinical Guideline**

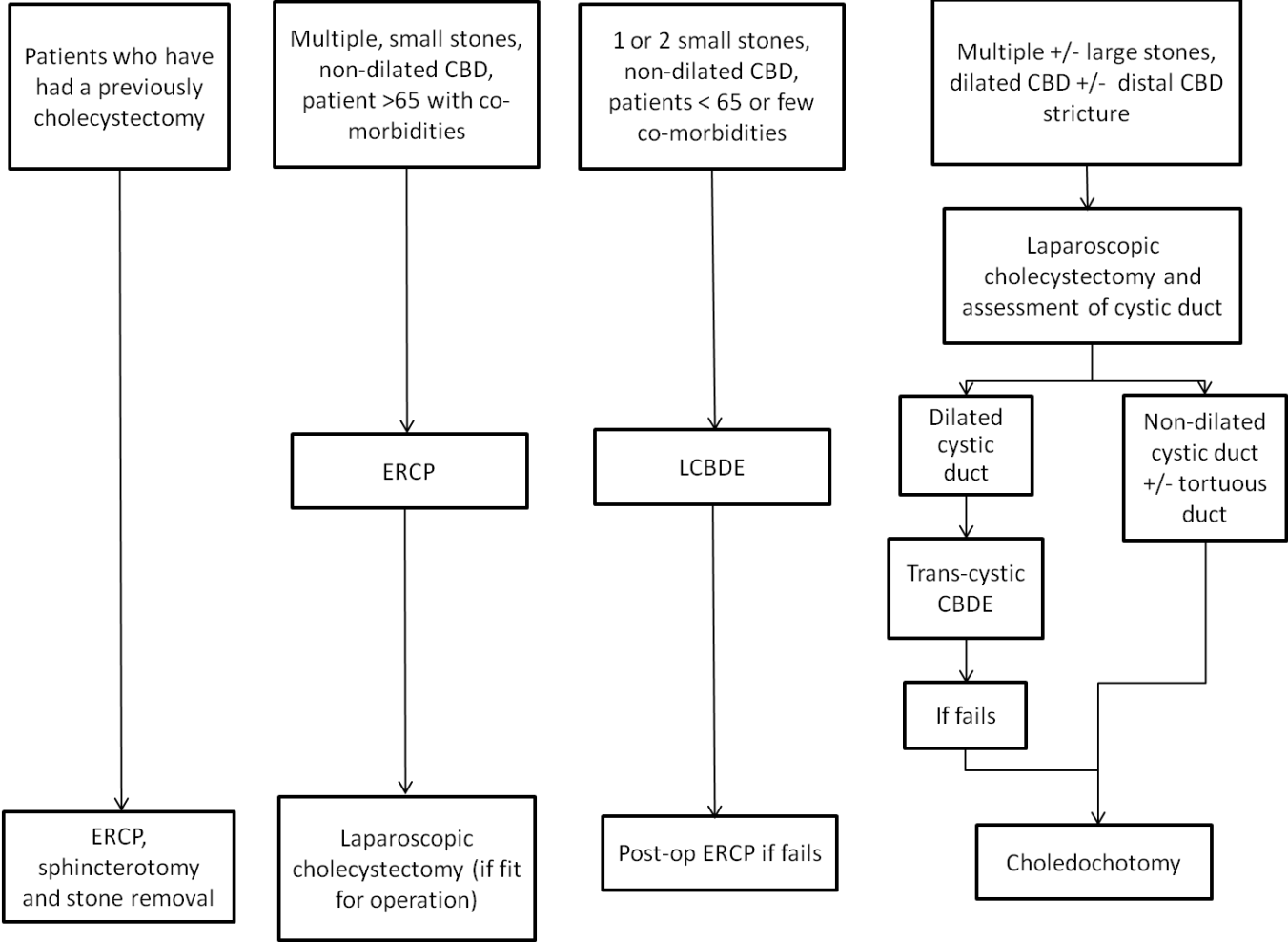
Reference no.: CG-T/2024/193

**Investigation of suspected CBD stones**



\*low likelihood= normal USS/LFTs and low clinical suspicion; moderate likelihood= CBD dilatation on USS with normal LFTs or abnormal LFTs with normal CBD on USS; high likelihood= CBD stone on USS, feature of cholangitis or pain/duct dilatation/jaundice in a patient with a history of gallstones

# Management of CBD stones



*LCBDE – laparoscopic common bile duct exploration, CBDE – common bile duct exploration*

## Preparation and considerations for ERCP

RDH requests will be made using Lorenzo (ERCP.). QHB requests are made using V6 for out-patients or paper request for in-patients (paper requests will be scanned into V6). For clinically urgent cases the Requesting Consultant should undertake direct discussion with an ERCP endoscopist as lists may need to be re-prioritised.

### Preparation

- Consent the patient (@ RDH the patient will be provided with a ERCP consent booklet which the patient should sign after reading).
  - Post-ERCP pancreatitis (1.3-6.7%). The risk is as high as 25% for patients undergoing ERCP for sphincter of oddi dysfunction (SOD).
  - Gastrointestinal haemorrhage (0.7-2%)
  - Cholangitis (0.5-5%)
  - Duodenal perforation (0.3-1%)
  - Miscellaneous, including cardiorespiratory (0.5-2.3%)
- FBC/INR within 72 hours of procedure. An INR  $\geq 1.5$  and/or platelets  $< 70,000$  will need correcting pre-ERCP (biliary obstruction is associated with vitamin K malabsorption and any coagulopathy will usually correct within 12 hours of IV Vit. K)
- Biliary sphincterotomy can be safely performed on patients taking Aspirin and prophylactic low-dose Heparin. Clopidogrel should be stopped for 7 days, DOAC for 72hrs and warfarin for 5 days with repeat INR. The endoscopist should give guidance on when to restart anticoagulation/antiplatelet therapy post-sphincterotomy though in most cases this will not be before 48 hours
- Prophylactic antibiotics (Ciprofloxacin 750mg orally 1hr pre-procedure) should be prescribed to all patients. If a patient is currently prescribed antibiotics for cholangitis then additional prophylactic antibiotics are not required
- Diclofenac 100mg PR (1hr pre-procedure) should be given except in those with an eGFR  $< 30$  or where clear contraindications to NSAIDs in order to reduce the incidence of post-ERCP pancreatitis
- 500ml 0.9% saline should be given over 1hr prior to the procedure to reduce risk of dehydration and renal impairment post procedure.

### Preparation and considerations for PTC

- Patients should have stopped clopidogrel for 7 days, Warfarin for 5 days, Aspirin for 5 days, DOAC for 72hrs and therapeutic LMWH for 24hrs prior to the procedure.
- Ensure Hb > 80, Plts > 50 and INR < 1.5
- Patients should be Nil to eat for 6hrs and clear fluids only up until 3hrs before procedure. Patients will often benefit from the administration of iv fluids in the period before and after PTC. This should, however, be assessed on an individual basis following review of blood results and patient clinical stability, NBM status and how long the patient has not been taking diet and fluids (clinical condition and background). If needed, please seek guidance from Hepato-Biliary Consultant or Interventional Radiology Consultant.
- Co-amoxiclav 1.2g (or Gentamicin 1.5 mg/kg and Metronidazole 500mg iv if penicillin allergic), cyclizine 50 mg and Diclofenac 100mg PR (provided eGFR >30) 1hr pre-procedure. Add Teicoplanin 400mg iv if known MRSA carriage.
- Patients should also receive oral loading dose of paracetamol:

Adult patients <65kg = 1500mg

Adult patients >65kg = 2000mg

In accordance with the Guideline for Oral Loading Doses of Paracetamol in Adults prior to Theatre (Reference No: CG-T/2014/128)

- Consent the patient for:

Bleeding  
Bile leak  
Failure  
Infection/bacteraemia  
Pancreatitis