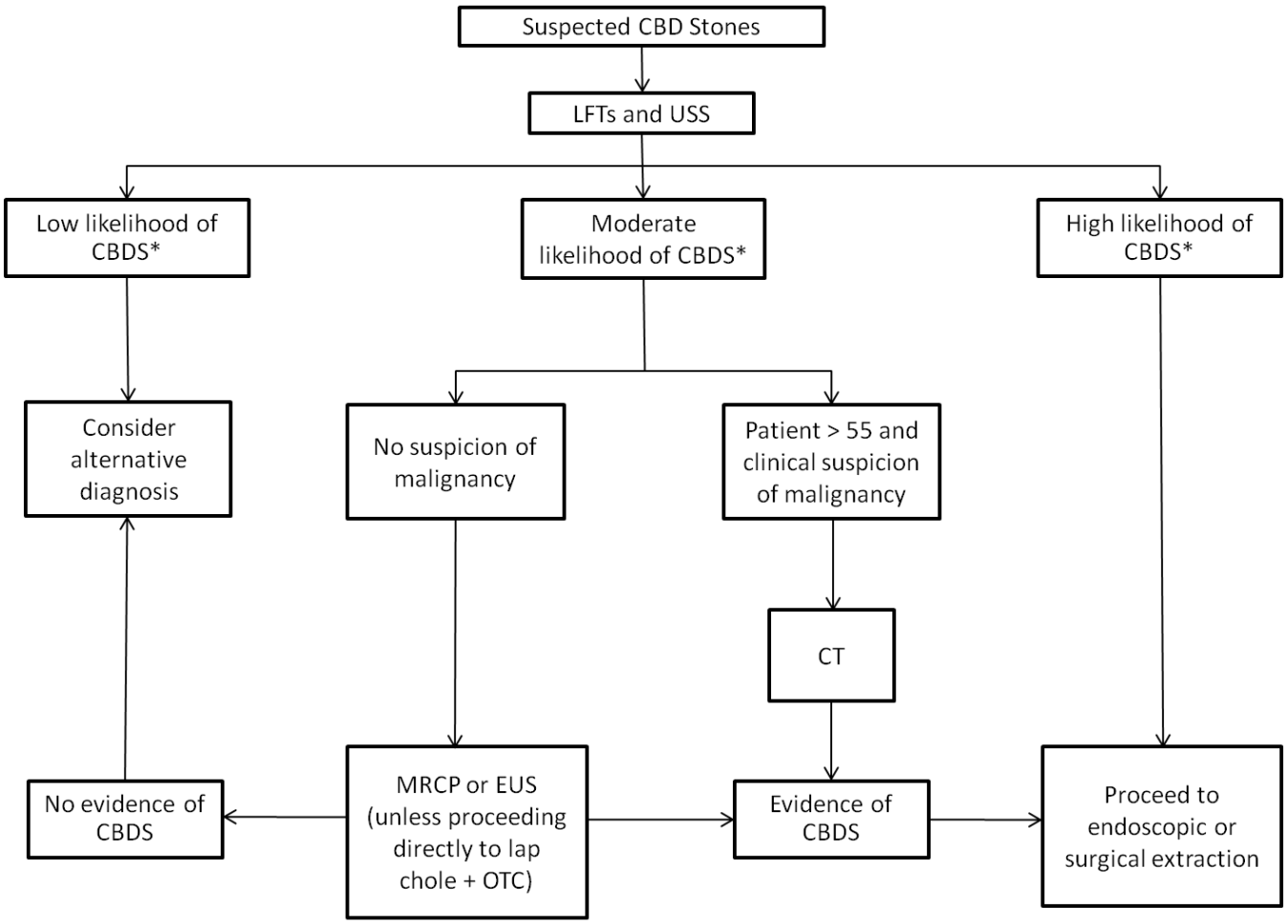
Management of Common Bile Duct (CBD) Stones and ERCP/ PTC Preparation - Summary Clinical Guideline

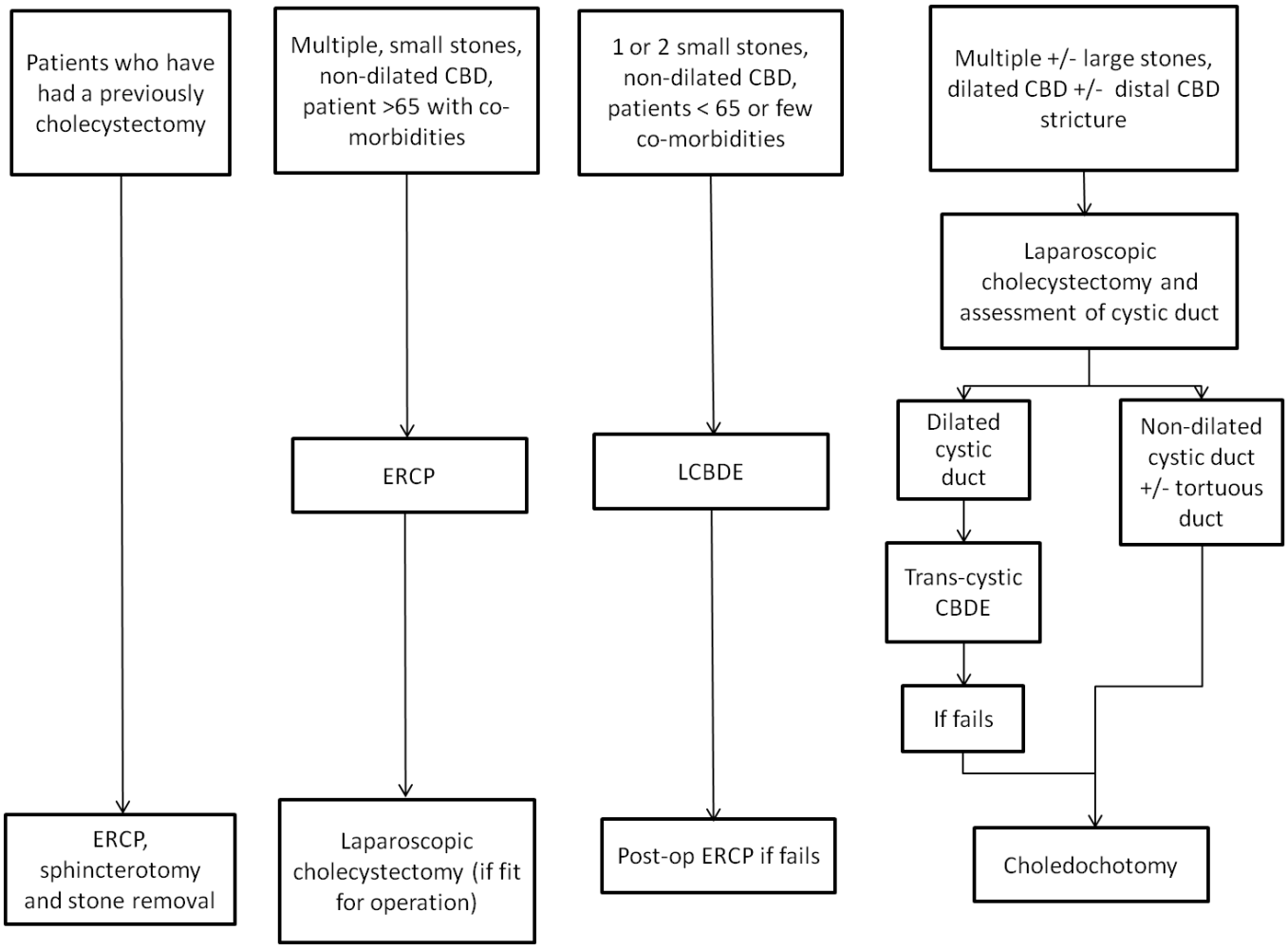
Reference no.: CG-T/2014/193

Investigation of suspected CBD stones



*low likelihood= normal USS/LFTs and low clinical suspicion; moderate likelihood= CBD dilatation on USS with normal LFTs or abdnormal 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

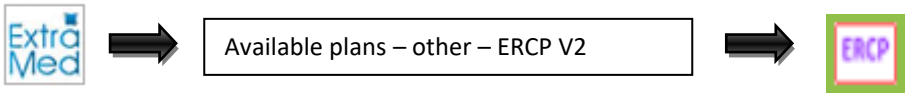
Management of CBD stones



LCBDE – laparascopic common bile duct exploration, CBDE – common bile duct exploration

Preparation and considerations for ERCP

At present ERCP referrals can be made either via ICM or through electronic whiteboard using the extramed icon on the flo website. The electronic white board request will be withdrawn when the ICM form moves to Lorenzo.
(http://extramed/pfm/Security/Authentication/login)



Preparation

- Consent the patient (designated ERCP consent forms available)
    - 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 ≥ 1.4 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 48hrs 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, in order to reduce 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 48hrs 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 patients 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 > 60) 1hr pre-procedure. Add Teicoplanin 400mg iv if known MRSA carriage (comprehensive antibiotic guidance for IR procedures is available via the trust guidelines page).
- 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
- Consent the patient for:

  Bleeding
  Bile leak
  Failure
  Infection/bacteraemia
  Pancreatitis