University Hospitals of Derby and Burton NHS Foundation Trust

Gall bladder Polyps - Full Clinical Guideline

Reference no.: CG-SURHEP/2017/001

1. Introduction

Gallbladder polyps are found incidentally in adults of Western populations (1 to 5%) and Asian (9.6%) populations during ultrasound scan or after cholecystectomy. Between 0.6% and 4% of the cholecystectomies are performed for gallbladder polyps.

The majority of gall bladder polyps are benign and made up of cholesterol polyps, adenomyomatosis and inflammatory polyps. A small proportion (5%) of polyps are 'true' adenomatous gallbladder polyps with malignant potential, hence the need for surveillance.

The size of the polyp is the most significant risk factor with 8% of polyps being malignant when >10mm. Laparoscopic cholecystectomy remains the mainstay treatment for gallbladder polyps that are symptomatic and/or show features suspicious of malignancy.

A management approach based on risk assessment, surveillance planning and MDT discussion should be adopted with high-risk cases.

2. Aim and Purpose

To provide guidance on the diagnosis of gallbladder polyps and the protocol to follow with regards to surveillance.

3. Definitions, Keywords

Gall bladder polyp (GBP), Adenomyomatosis, Cholecystectomy, Malignancy

4. Main body of Guidelines

Risk factors for malignant polyp

- Age > 60
- Asian ethnicity
- Sessile or single polyp
- Size of the polyp (when multiple take the size of the dominant polyp)
- Change in size of polyp
- Gallstones
- Cholecystitis
- Gall bladder wall thickening (Imaging)
- Primary Sclerosing Cholangitis

Management

- Polypoid lesion of the gallbladder greater than or equal to 10mm should be regarded as potentially malignant. Cancers at 10mm are usually at an early stage and laparoscopic cholecystectomy with full thickness dissection (removal of the entire connective tissue layers of gall bladder bed to expose the liver surface) is recommended.

  CT scan is required assessing invasion into the liver or surrounding structures. Such features would indicate the need for radical surgery by referral from MDT to the regional cancer centre.

  EUS can be used in selectively where there is doubt in diagnosis or invasion to surrounding structures.

- Cholecystectomy is also advised in patients with Polyps <10 mm in size and biliary type pain. The clinician must take care to assess that there is no alternative cause for the patient's symptoms.

- Asymptomatic polyps <10 mm – management depends on risk factors

  - 6-9 mm polyp with presence of risk factors – patients with risk factors have a higher risk of gall bladder malignancy. As such, the threshold of 10 mm as an indication for cholecystectomy should be lowered.

  - 6-9 mm polyp without risk factors for malignancy **OR** < 6 mm polyp with presence of risk factors – Follow up USS at 6 months, 1 year then yearly up to 5 years.

  - <6 mm polyp without risk factors – Follow up USS at 12 months (Discharge if no change).

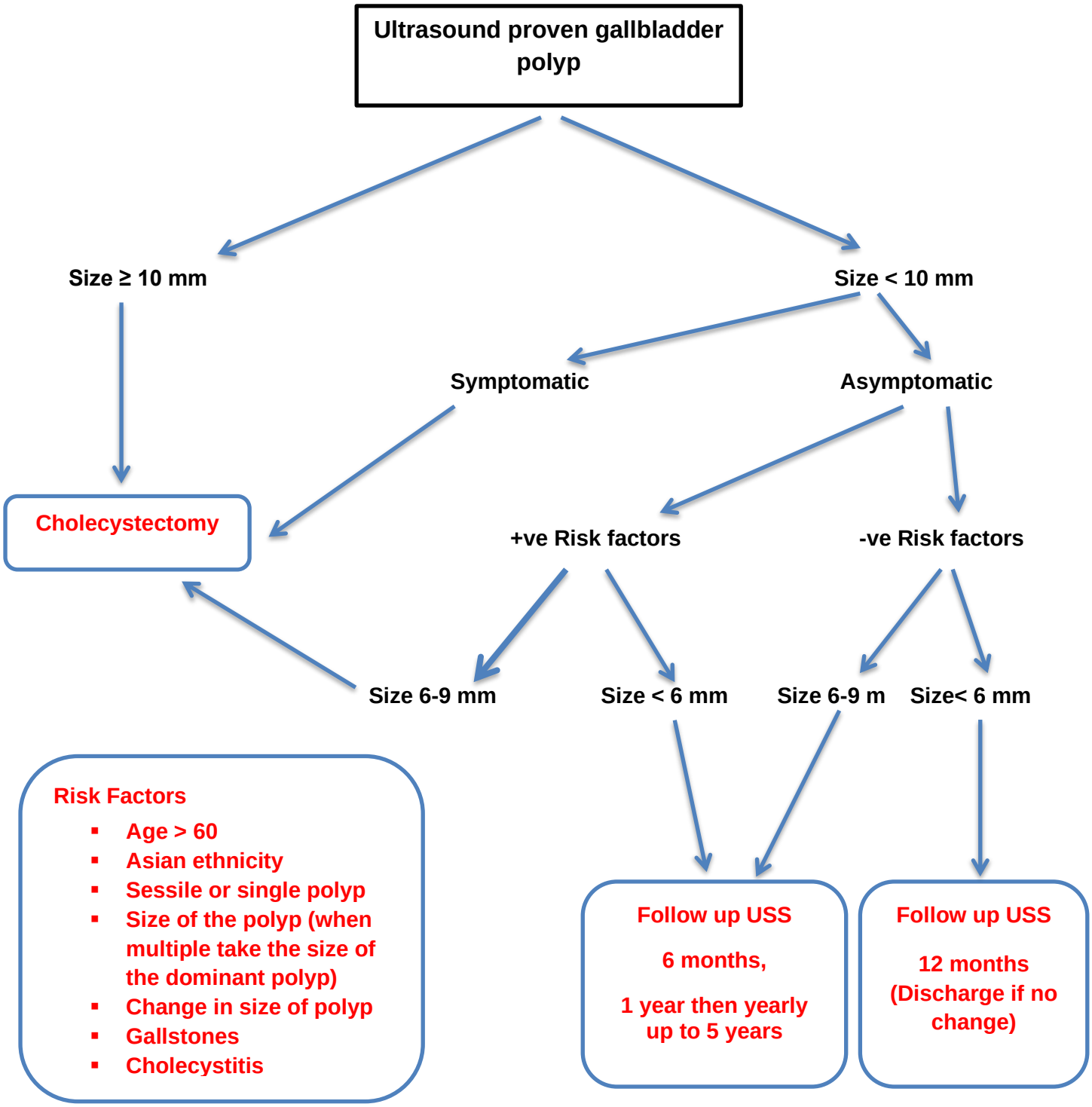
Follow up of polyp according to change in size

The most reassuring finding is the stability of a polyp on repeated follow-up examinations.

Stability of a gall bladder polyp is usually defined by <2 mm change in size. If the polyp crosses into a higher size bracket, then please follow the new corresponding pathway.

If during follow up polyp:

- Increases by 2 mm or more →cholecystectomy advised
- Disappears → Discontinue follow up


Ultrasound proven gallbladder polyp
Size ≥ 10 mm
Size < 10 mm
Symptomatic
Asymptomatic
Cholecystectomy
+ve Risk factors
-ve Risk factors
Size 6-9 mm
Size < 6 mm
Size 6-9 m
Size< 6 mm
Risk Factors
Age > 60
Asian ethnicity
Sessile or single polyp
Size of the polyp (when multiple take the size of the dominant polyp)
Change in size of polyp
Gallstones
Cholecystitis
Follow up USS
6 months,
1 year then yearly up to 5 years
Follow up USS
12 months (Discharge if no change)

5. References

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6. Documentation Controls

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