

SHIP 8 Clinical Commissioning Groups' Priorities Committee Policy

CEC16/007 - Cholecystectomy for patients with asymptomatic gallstones

Date of issue (from SHIP 8 Priorities Committee): April 2016

Date of adoption (by NHS North Hampshire CCG): May 2016

The Priorities Committee have reviewed the evidence for cholecystectomy (removal of the gallbladder) for patients with asymptomatic gallstones and recommend that:

1. Cholecystectomy for asymptomatic patients with gallstones or those where gallstones are unlikely to be the cause of the symptoms is low priority.
2. Cholecystectomy as an opportunistic intervention in an incidentally found asymptomatic patient is low priority.
3. Cholecystectomy for gallstones in the bile duct is a high priority.

Supporting Information

Asymptomatic gallstones are gallstones found incidentally when having an ultrasound for another reason unconnected to gallstone disease and in patients who have been symptom free for at least 12 months.

The NICE Clinical Guideline (2014) on gallstone disease recommended that only symptomatic gallstones should be treated with laparoscopic cholecystectomy. The CG also recommended that surgery should be offered to patients with gallstones in the bile duct.

Epidemiology

- Gallstones occur most commonly in the bladder but also occur in other parts of the biliary tree. 20% of the adult population have asymptomatic gallstones and 70% of these will never have a clinical event. The incidence of developing symptoms is 2-4% per annum.
- There are 3 treatment options for gallstones: non-surgical treatments (lithotripsy or ursodeoxycholic acid which are both considered to be ineffective); conservative treatment (including weight loss and low-fat diet which is considered to be effective for some patients); and laparoscopic cholecystectomy surgery.
- Cholecystectomy is the most common gastro-intestinal surgical procedure performed in the UK; 128 per 100,000 population in 2013/14.
- There is a 3-fold variation in rates of cholecystectomy for CCGs across England.
- Risk factors for gallstones include rapid weight loss, chemotherapy and upper GI tract surgery. It is thought that because more people are being considered for bariatric surgery than 10 years ago and detection rates for abdominal cancer are higher that this is leading to an increase in incidentally discovered gallstones.

Clinical Effectiveness

There is no reliable evidence of clinical effectiveness to support routine concurrent cholecystectomy in general population, bariatric population, or abdominal cancer population for incidentally discovered, asymptomatic gallstones.

The limited evidence available is of poor quality. There were no RCTs and most studies were small and methodologically flawed. There were no long term outcomes, quality of life or adverse events data published.

Cost Effectiveness

The only evidence for cost effectiveness, concluded that concurrent cholecystectomy for asymptomatic gallstones is the least cost effective intervention and 4 times more expensive than conservative treatment. The authors suggested that it would cost €6 million per 10,000 asymptomatic patients for a concurrent cholecystectomy.

Notes:

Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.

This policy may be reviewed in the light of new evidence or guidance from NICE.