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Cholecystitis and Cholangitis

# Diagnosis

* Cholangitis: right upper quadrant (RUQ) pain (80%), fever (80%), jaundice (50%)
* In the absence of signs and symptoms of infection, patients with jaundice or non-obstructing gallstones do not require antibiotics
* Acute cholecystitis: RUQ pain, fever, nausea/vomiting, usually in the presence of gallstones
* In the absence of signs and symptoms of infection, patients with biliary colic (i.e., RUQ pain lasting 1–3 hours that resolves) do not require antibiotics
* Microbiology: *Escherichia coli, Klebsiella pneumoniae, Enterococcus* species
* Blood cultures should be obtained in all patients with cholangitis
* Blood cultures should be obtained in patients with cholecystitis that have concomitant sepsis
* Bile cultures should be obtained if the biliary tree is accessed via endoscopic retrograde cholangiopacreatography (ERCP) or percutaneous drainage
* RUQ ultrasound is the initial imaging modality of choice

# Treatment

* **Nonseverely ill patients with community-acquired infections**
* Coverage for *Enterobacteriaceae*
* [Place local recommendations here]
* [Place local recommendations here]

*Note:* Staphylococcus aureus,Pseudomonas aeruginosa, *and anaerobes are generally not biliary pathogens and do not require empiric coverage in nonseverely ill patients with community-acquired infections;* Enterococcus *species grow in the biliary tree but are of low virulence and do not require empiric coverage in this population.*

* **Patients with severe infection, hospital-acquired infection, or prior extensive biliary tract manipulation**
* Broader coverage for *Enterobacteriaceae*, *P. aeruginosa*,and anaerobes; consider coverage for *Enterococcus* species
* Review any prior biliary cultures to inform empiric therapy
* [Place local recommendations here]
* [Place local recommendations here]
* **Narrowing and oral therapy**
* Narrow based on available culture data
* Consider transition to oral therapy when clinical improvement (usually by 48–72 hours) and source control are achieved
* Oral therapy can be used for bacteremia if agents with good oral bioavailability are chosen (e.g., trimethoprim-sulfamethoxazole, fluoroquinolones, metronidazole)
* Oral options: [Place local recommendations here]

# Duration

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| Acute cholangitis and source control | 3 days after source control |
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| Acute cholangitis and source control with concomitant bacteremia | 7 days |
| Uncomplicated acute cholecystitis, medical management | 5-10 days based on clinical response\* |
| Uncomplicated acute cholecystitis, surgical management | No antibiotics after surgery |
| Complicated acute cholecystitis (e.g., perforation, fistula), surgical management for source control | 4 days after surgery |

\*Recommendations are for patients without significant immunocompromise or complex presentations; relevant multispecialty consultation, including infectious diseases, should be considered for cases falling outside of the scope of these recommendations.

# References

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