Acalculous Cholecystitis

85

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Algorithmic Approach

A. Acute acalculous cholecystitis (AAC), representing only 5–10% of all cases of cholecystitis, is inflammation of the gallbladder which is not associated with the presence of gallstones [1, 2]. This pathology was described initially in critically ill patients who underwent major surgery or in the setting of extensive burns [1]. Ischemia is the most likely underlying cause of acute acalculous cholecystitis [1]. Clinical findings of AAC can be difficult to distinguish from calculous cholecystitis. Oftentimes, the clinical signs and laboratory workup are nonspecific [3].

Treatment of acute acalculous cholecystitis consists of early radiologic imaging and effective management. The three most common treatments are open cholecystectomy, laparoscopic cholecystectomy, or percutaneous cholecystostomy [4], depending on severity of disease.

B, C. Imaging plays a major role in the accuracy of diagnosis and management. Which study to begin with, an ultrasound, a CT scan, or a HIDA scan, is debatable [5]. Sonographic features of abdominal circumference (AC) include an abnormally distended GB, wall thickening, pericholecystic fluid (without ascites), and sludge (in the absence of cholelithiasis) [6].

D. Patients who are deemed clinically stable for a laparoscopic cholecystectomy should undergo surgery early in the disease process. If the patient is critical with multiple comorbidities or a poor surgical candidate, then percutaneous cholecystostomy tube placement is a safer choice. In some papers, there is a higher incidence of gangrenous cholecystitis of 31% compared to calculous cholecystitis of 5.6% [7]. Mortality from acute acalculous cholecystitis is at least 30% because of the association of gangrene and the rapid disease progression in critically ill patients [8, 9].

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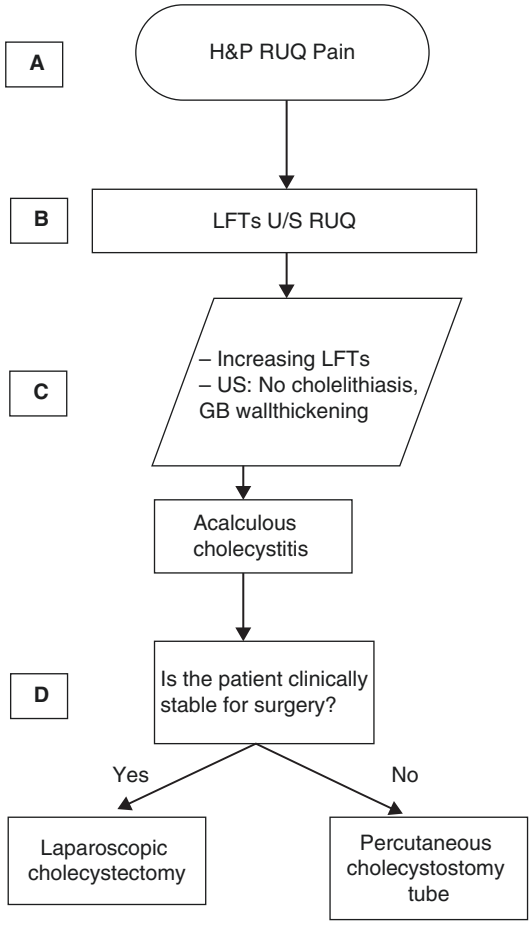

Algorithm 85.1

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