Acute cholecystitis

- Appropriate management of acute cholecystitis depends on the severity of disease.
- Broad spectrum antibiotics until either 24h post cholecystectomy or the cholecystitis clinically resolves.
    - Low risk patients: combination of Metronidazole with either Ceftriaxone or Ciprofloxacin
    - High risk patients: Pip/Tazo or combination of Metronidazole and Cefepime
    - ESBL risk: Meropenem
    - Beta lactams and carbapenem contraindication: combination of Metronidazole Vancomycin, and Aztreonam

Mild acute cholecystitis

- Laparoscopic cholecystectomy during same hospitalization if pt is a good surgical candidate
    - E*arly* as long as it is completed within 10 days of onset of symptoms
    - Should not be considered beyond 10 days from the onset of symptoms unless worsening peritonitis or sepsis. If beyond 10 days, delaying cholecystectomy for 45 days is better than immediate surgery.

Moderate acute cholecystitis

- Defined by:
    - Persistent leukocyte count >18,000
    - Palpable tender mass or marked local inflammation in the RUQ
- May be managed by either early or delayed cholecystectomy

Severe acute cholecystitis

- Define by associated organ failure/sepsis
    - Percutaneous cholecystostomy

Emergent cholecystectomy

- Clinical deterioration at any time or no improvement after 1 or 3 days post percutaneous or endoscopic drainage
- Gallbladder gangrene/necrosis
- Gallbladder perforation
- Emphysematous cholecystitis

Emergent ERCP is associated with cholangitis

Reassess surgical risk after resolution of cholecystitis

- Elective laparoscopic surgery if good surgical candidate
- Nonsurgical stone dissolution, extraction or observation