I'm not robot
reCAPTCHA
Continue

Acute cholangitis treatment guidelines

Auteur Homayoun Shojamanesh, MD Ancien Fellow, Digestive Diseases Branch, National Institutes of Health Homayoun Shojamanesh, MD est membre des sociétés médicales suivantes: American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal EndoscopyDisclosure: Rien à divulguer. Coauteur(s) Praveen K Roy, MD, AGAF Clinical Assistant Professor of Medicine, University of New Mexico School of Medicine Praveen K Roy, MD, AGAF est membre des sociétés médicales suivantes : American Gastroenterological Association, American Society for Gastrointestinal EndoscopyDisclosure: Rien à divulguer. Victor Nwakakwa, MD, MRCP Disclosure: Rien à divulguer. Conseil d'administration spécialisé Francisco Talavera, PharmD, PhD Adjunct Assistant Professor, University of Nebraska Medical Center College of Pharmacy; Rédacteur en chef, Medscape Drug ReferenceDisclosure: Reçu un salaire de Medscape pour l'emploi. pour: Medscape. BS Anand, MD Professeur, Département de médecine interne, Division de gastroentérologie, Baylor College of Medicine BS Anand, MD est membre des sociétés médicales suivantes: American Association for the Study of Liver Diseases, American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal EndoscopyDisclosure: Rien à divulguer. Rédacteur en chef Vinay Kumar Kapoor, MBBS, MS, FRCS, FAMS Professeur de gastroentérologie chirurgicale, Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow, Inde Vinay Kumar Kapoor, MBBS, MS, FRCS, FAMS est membre des sociétés médicales suivantes: Association of Surgeons of India, Indian Association of Surgical Gastroenterology, Indian Society of Gastroenterology, Medical Council of India, National Academy of Medical Sciences (Inde), Royal College of Surgeons of EdinburghDisclosure: Rien à divulguer. Autres contributeurs Anil Minocha, MD, FACP, FACG, AGAF, CPNSS Professeur de médecine, Directeur des maladies digestives, Directeur médical du soutien nutritionnel, Directeur médical de l'endoscopie gastro-intestinale, Département de médecine interne, Centre médical de l'Université du Mississippi; Professeur clinique, University of Mississippi School of Pharmacy Anil Minocha, MD, FACP, FACG, AGAF, CPNSS est membre des sociétés médicales suivantes: American Academy of Clinical Toxicology, American Society for Gastrointestinal Endoscopy, American Federation for Clinical Research, American Association for the Study of Liver Diseases, American College of Forensic Examiners Institute, American College of Gastroenterology, American College of Physicians, American Gastroenterological AssociationDisclosure: Rien à divulguer. Mise à jour: 7 décembre 2018 • Tokyo Guidelines 2018: antimicrobien therapy for acute cholangitis and cholecystitis (• Tokyo Guidelines 2018: diagnostic criteria and severity grading of acute cholangitis (avec vidéos) Tokyo 2018 Guidelines: Initial management of acute bile infection and frequency of acute cholangitis (- Bile cholang drainage indications and techniques Acute guidelines in the 2018 (updates from Tokyo (- Tokyo Guidelines 2018: Diagnostic criteria and classification of the severity of cholecys Acutetitis (with videos) (- Tokyo Guidelines 2018: flowchart for the management of acute cholecystitis (- Tokyo Guidelines 20 18: surgical management of acute cholecystitis:safe steps in laparoscopic cholecystectomy for acute cholecystitis (with videos) (Tokyo Guidelines 2018 : management strategies for gallbladder drainage in patients with acute cholecystitis (with videos) (- Tokyo Guidelines 2018: links of management of acute cholangitis and cholecystitis (- Preoperative conversion predictors as indicators of local inflammation in the c acuteholecystitis: Strategies for future studies to develop quantitative predictors (TG18 Mobile Application (in English and Japanese) TG18 Digest, including diagnostic criteria calculators and evaluation of the severity of acute cholangitis and cholecystitis is now available with a mobile application (for i-Phone, Android) and you'll be able to download the app through the Apple Store and Google play sites. Site URLs and QR codes are shown below; Apple Store (for i-Phone users) Google Play (for Android users) Search and install an app called Tokyo Guidelines (TG18) on your mobile. The app is free. CQ in TG18 (in Japanese) 1 抗菌薬 (antimicrobial therapy) References and files on the first decision meeting of March 30, 2017 (PDF) References and files with memo on the meeting of Final decision of April 29, 2017 (PDF) References and files without memo at the final decision meeting of April 29, 2017 (PDF) 2 急胆管炎診断基準症度判定基準 (Diagnosis and severity classification of acute cholangitis) References and files from the first decision meeting of March 30, 2017 (PDF) References and files with memo on the final decision meeting on March 30, 20 17 April 29, 2017 (PDF) References and files without a memo on the final decision meeting of April 29, 2017 (PDF) 3 急胆管炎 for the management of acute cholangitis) References and files on the first decision meeting on March 30, 2017 (PDF) References and files with memo on the final decision meeting of April 29, 2017 (PDF) References and files without Memo at the final decision meeting of April 29, 2017 (PDF) 4 急胆管炎 (bile drainage for acute cholangitis) References and files on the first decision meeting decision March 30, 2017 (PDF) References and files with memo on the final decision meeting of April 29, 2017 (PDF) References and files without memo on the final decision meeting of April 29, 2017 (PDF) 5-急 references and files from the first decision meeting of March 30, 2017 (PDF) References and files with memos on the final decision meeting of March 29, references and files for acute cholecystitis胆嚢炎 April 2017 (PDF) References and files without memo on the final decision meeting on April 29, 2017 (PDF) References and files without memo on the final decision meeting on April 29, 2017 (PDF) 6-急 References and files from the first decision meeting of March 30, 2017 (PDF) References and files with memos on the final meeting of April 29, 2017胆嚢炎診断基準症度判定基準 201717 (PDF) References and files without a memo at the final decision meeting of April 29, 2017 (PDF) 7胆嚢炎 急 - (Flowchart for the management of acute cholecystitis) References and files from the first decision meeting on March 30, 2017 (PDF) References and files with memo on the final decision meeting of April 29, 2017 (PDF) References and files without a memo on the final decision meeting of April 29, 2017 (PDF) 8 -Lap-Csafety (Safe Steps in cholecyst laparoscopicectomy for acute cholecystitis) References and files from the first decision meeting of March 30, 2017 (PDF) References and files with memo on the Final Decision Meeting of April 29, 2017 (PDF) References and files without memo on the final decision meeting on April 29, 2017 (PDF) Page 2Copyright © Japanese Society of Hepato-biliary-Pancreatic Surgery , all rights reserved. Page 3 If not recognized and treated appropriately, ascending cholangitis can cause significant morbidity to affected patients. Accurate diagnosis and assessment of the severity of the disease is essential to guide antimicrobial selection, timing of bile decompression, and selection of a decompression technique. This article reviews the current literature related to the bottom-up management of cholangitis, along with current international guidelines. Dan McEntire MD, Douglas G. Adler MD, University of Utah School of Medicine, Gastroenterology and Hepatology, Salt Lake City, UT INTRODUCTION Ascending cholangitis (AC) is an infection of the bile tract. The normal bile tree is an almost sterile secondary to constant drainage, bacteriostatic bile salts, and mucous immune mechanisms. Bile obstruction disrupts these processes and causes high intraductive pressure with increased bile duct permeability, which allows bacterial endotoxin and translocation in the lymphatic circulation and bile obstruction is most commonly caused by gallstones, although there are many causes, including the mass effect of malignancy, benign and malignant restrictions, parasites (e.g., Ascaris) and iatrogenic causes (e.g., bile tangle, surgery).1 (Figures 1 and 2) Organisms involved in KT originate from enteric flora, and crops are generally polymicrobial.2 The most frequently isolated gramative organisms are isolated. coli and K. pneumoniae, with species of Enterococcus being the most common gram-positive organism.3,4 Anaerobes, mainly Bacteroides and Clostridium, are relatively rarely isolated.3,4 Accurate diagnosis and severity assessment are fundamental to guide appropriate therapy. In addition to clinical support and resuscitation, antibiotic administration and bile decompression are the central components of KT management. This article presents current data relevant to these areas. Diagnosis of ascending cholangitis Classic clinical characteristics of KT are fever, abdominal pain of the right upper quadrant (RUQ) and jaundice (Charcot triad). More severe cases may present with hypotension and altered mental status (Reynold Pentad). However, because few cases present with all of these devices, standardized criteria have recently been developed.5,6 The current Tokyo 2018 (TG18) diagnostic criteria for AC are based on evidence of systemic inflammation, choletase, and bile obstruction. Systemic inflammation is defined as fever - 38 degrees Celsius, chills shaking, leukocyte counts are defined as leukocyte counts, or C-reactive protein (CRP) ≥1 mg/dL. Cholestasis is defined as clinical jaundice, total bilirubin ≥ 2 mg/dL, or alkaline phosphatase, aminotransferase aspartate, aminotransferase alanine or gamma-glutamyltransferase 1.5 times the upper limit of normal. The presence of bile dilation, or evidence of etiology (e.g., stone, rigor), indicates an obstruction. A definitive diagnosis is made when at least one criterion is met in each of the three categories. A suspicious diagnosis is made when a criterion is met in the systemic category of inflammation, plus an element in the cholestasis or imaging categories. One study found that the diagnostic criteria were able to identify 90% (73.1% definitive, 16.9% suspected) of the cases.7 The remaining 10% undiagnosed were mild cases that missed systemic inflammation. This suggests reasonable performance of the criteria, especially for moderate to severe disease. Imaging is necessary to make a definitive diagnosis of cholangitis (although clinical suspicion may be high in known cases of pre-existing pancreatic disease). Abdominal ultrasound (US) is the first recommended step due to its high availability, non-invasive nature and low cost. The United States is well suited for visualizing the proximal joint bile duct (CBD) and the common liver duct, but visualization of distal CBD is typically limited. Computed tomography (CT) and magnetic resonance imaging/magnetic resonance cholangiopancreatography (MRI/MRCP) may Executed. Mri/MRCP is favored given high-resolution image formation of the common bile duct that is possible. Invasive endoscopic or percutaneous imaging options, discussed below, can be both diagnostic and therapeutic. The TG18 ascending cholangite severity ranking includes a severity classification system that has prognostic value and can help guide the appropriate time of intervention.5 III (grave) cholangitis se manifeste par l'évidence du dysfonctionnement d'organe. Le dysfonctionnement des organes est défini comme la présence d'un dysfonctionnement cardiovasculaire nécessitant une dopamine intraveineuse >5µg/kg/min ou toute dose de noradrénaline, dysfonctionnement neurologique (c.-à-d. perturbation de la conscience), dysfonctionnement respiratoire (PaO2/FiO2 <300), renal= dysfunction= (oliguria= or= serum= creatinine=>2mg/dL), dysfonctionnement hépatique (INR >1,5), ou dysfonctionnement hématologique (nombre de plaquettes <100,000 l).= grade= ii= (moderate)= cholangitis= is= defined= by= the= presence= of= high= fever= (=>39°C), nombre de leucocytes <4,000 l= or=>12 000/µL, âge avancé (>75 ans), ou hypoalbuminémie (<70% lower limit of normal). Grade I (mild) cholangitis lacks the aforementioned criteria. A large study that stratified patients by severity grade found 5.1%, 2.6%, and 1.2% 30-day mortality in patients with Grade III, II, and I disease, respectively.7 Antibiotics Initiation of antibiotics should occur within one hour in cases of sepsis, or within six hours for all other cases.4,8 Prescribing adequate empiric coverage is becoming increasingly difficult due to antibiotic resistance patterns.2,9 Appropriate selection of empiric coverage is also made with consideration given to comorbidity, allergy, or other factors. General recommendations for empiric coverage

include intravenous treatment with a third-generation cephalosporin or a penicillin derivative/beta-lactamase inhibitor combination.4 TG18 and the Surgical Infection Society/Infectious Disease Society of America (SIS/IDSA) guidelines recommend to consult local antibiograms and administer alternative medications if community pathogen resistance exceeds 10-20%.4,10 Ampicillin-sulbactam and fluoroquinolones are not recommended for empiric use due to widespread E. coli resistance, but are frequently used in clinical practice.2,4,9,10 Antipseudomonal agents can be reserved for severe cases and healthcare-associated infection.3,4 Coverage of Enterococcus species with vancomycin is recommended in severe or healthcare-associated disease, or in immunocompromised patients.4,10 Anaerobic coverage with metronidazole is recommended in patients with a surgical history of biliary enteric anastomosis or for general prophylaxis.4 ,10 This is due to a relative scarcity of anaerobe isolation in AC, and reports that anaerobic coverage for other indications does not improve outcomes.2,3,11,12,13 Antibiotic treatment can be adjusted based on patient response and pathogen susceptibility data. TG18 and SIS/IDSA guidelines recommend a total of 4-7 days of therapy after source control is obtained, obstruction removed, and assuming absence of local complications (e.g., liver abscess).4,10 In the presence of Gram-positive bacteremia, 2 weeks of therapy is recommended.4 Timing of Biliary Decompression Several studies, mostly related to ERCP, have assessed outcomes in AC patients with regards to time-to-intervention but a clear consensus has not been well defined. Based on findings lower= limit= of= normal).= grade= i= (mild)= cholangitis= lacks= the= aforementioned= criteria.= a= large= study= that= stratified= patients= by= severity= grade= found= 5.1%,= 2.6%,= and= 1.2%= 30-day= mortality= in= patients= with= grade= iii,= ii,= and= i= disease,= respectively.7= antibiotics= initiation= of= antibiotics= should= occur= within= one= hour= in= cases= of= sepsis,= or= within= six= hours= for= all= other= cases.4,8= prescribing= adequate= empiric= coverage= is= becoming= increasingly= difficult= due= to= antibiotic= resistance= patterns.2,9= appropriate= selection= of= empiric= coverage= is= also= made= with= consideration= given= to= comorbidity,= allergy,= or= other= factors.= general= recommendations= for= empiric= coverage= include= intravenous= treatment= with= a= third-generation= cephalosporin= or= a= penicillin= derivative/beta-lactamase= inhibitor= combination.4= tg18= and= the= surgical= infection= society/infectious= disease= society= of= america= (sis/idsa)= guidelines= recommend= to= consult= local= antibiograms= and= administer= alternative= medications= if= community= pathogen= resistance= exceeds= 10-20%.4,10= ampicillin-sulbactam= and= fluoroquinolones= are= not= recommended= for= empiric= use= due= to= widespread= e.= coli= resistance ,= but= are= frequently= used= in= clinical= practice.2,4,9,10= antipseudomonal= agents= can= be= reserved= for= severe= cases= and= healthcare-associated= infection.3,4= coverage= of= enterococcus= species= with= vancomycin= is= recommended= in= severe= or= healthcare-associated= disease,= or= in= immunocompromised= patients.4,10= anaerobic= coverage= with= metronidazole= is= recommended= in= patients= with= a= surgical= history= of= biliary= enteric= anastomosis= or= for= general= prophylaxis.4,10= this= is= due= to= a= relative= scarcity= of= anaerobe= isolation= in= ac,= and= reports= that= anaerobic= coverage= for= other= indications= does= not= improve= outcomes.2,3,11,12,13= antibiotic= treatment= can= be= adjusted= based= on= patient= response= and= pathogen= susceptibility= data.= tg18= and= sis/idsa= guidelines= recommend= a= total= of= 4-7= days= of= therapy= after= source= control= is= obtained,= obstruction= removed,= and= assuming= absence= of= local= complications= (e.g. ,= liver= abscess).4,10= in= the= presence= of= gram-positive= bacteremia,= 2= weeks= of= therapy= is= recommended.4= timing= of= biliary= decompression= several= studies,= mostly= related= to= ercp,= have= assessed= clinical= outcomes= in= ac= patients= with= regards= to= time-to-intervention= but= a= clear= consensus= has= not= been= well= defined.= based= on= findings=></70% lower limit of normal). Grade I (mild) cholangitis lacks the aforementioned criteria. A large study that stratified patients by severity grade found 5.1%, 2.6%, and 1.2% 30-day mortality in with Grade III, II, and I disease, respectively.7 Antibiotics Initiation of antibiotics should occur within one hour in cases of sepsis, or within six hours for all other cases.4,8 Prescribing adequate empiric coverage is becoming increasingly difficult due to antibiotic resistance patterns.2,9 Appropriate selection of empiric coverage is also made with consideration given to comorbidity, allergy, or other factors. General recommendations for empiric coverage include intravenous treatment with a third-generation cephalosporin or a penicillin derivative/beta-lactamase inhibitor combination.4 TG18 and the Surgical Infection Society/Infectious Disease Society of America (SIS/IDSA) guidelines recommend to consult local antibiograms and administer alternative medications if community pathogen resistance exceeds 10-20%.4,10 Ampicillin-sulbactam and fluoroquinolones are not recommended for empiric use due to widespread E. coli resistance, but are frequently used in clinical practice.2,4,9,10 Antipseudomonal agents can be reserved for severe cases and healthcare-associated infection.3,4 Coverage of Enterococcus species with vancomycin is recommended in severe or healthcare-associated disease, or in immunocompromised patients.4,10 Anaerobic coverage with metronidazole is recommended in patients with a surgical history of biliary enteric anastomosis or for general prophylaxis.4 ,10 This is due to a relative scarcity of anaerobe isolation in AC, and reports that anaerobic coverage for other indications does not improve outcomes.2,3,11,12,13 Antibiotic treatment can be adjusted based on patient response and pathogen susceptibility data. TG18 and SIS/IDSA guidelines recommend a total of 4-7 days of therapy after source control is obtained, obstruction removed, and assuming absence of local complications (e.g., liver abscess).4,10 In the presence of Gram-positive bacteremia, 2 weeks of therapy is recommended.4 Timing of Biliary Decompression Several studies, mostly related to ERCP, have assessed clinical outcomes in AC patients with regards to time-to-intervention but a clear consensus has not been well defined. Based on findings > </4,000> </100,000> </300),> </300),> Improved mortality in patients with grade II (moderate) disease who received bile drainage within 48 hours, TG18 generally recommends decompression within 48 hours in patients.5,7 In practice, however, sometimes patients are too unstable to undergo a drainage procedure and require more time before bile decompression. Recommendation for 48 hours as a general cut is supported by investigators who have found worse results (persistent organ failure, longer hospitalization, relapse, or mortality) in patients with more delayed decompression.14, 15, 16, 17, 18 In contrast, other accounts promote decompression within 24 hours, mostly on the basis of shorter hospitalization.16,17,19,20,21 A recent study describes ambulatory management of KT after endoscopic drainage, suggesting that early intervention in mild to moderate disease may prevent hospitalization altogether. 22 Patients with septic shock or critical disease appear to warrant decompression early after proper resuscitation, with significantly improved mortality reported when decompressed before 12 or 24 hours, respectively.23,24 Bile drainage techniques bile drainage is recommended for all cases of AC, regardless of severity.25 Techniques for bile decompression are widely categorized in the endoscop drainage, percutaneous, and surgical. Endoscopic BILe decompression of ERCP bile drainage by direct cannulation of the main duodenal papilla is the gold standard for acute cholangitis.25,26 This is due to high success rates, minimally invasive nature, and fewer adverse events compared to percutaneous or surgical procedures.26,27,28,29 inconveniences, however, include the need for sedation.30 endoscopic sedation clearance by sphincterotomy, balloon extraction, and/or endoscopic stenting for restrictions is performed as required. Patients in whom stone extraction cannot be carried out may simply undergo stent placement. An additional technique is direct cholangioscopy with lithotripsy. Nasobiliary drains are rarely used in modern practice.26,27,31 Balloon-assisted enteroscopy ERCP (BE-ERCP) is recommended in cases of impaired postoperative anatomy.25 Endoscopic ultrasound bile drainage (EUS-BD) is a relatively new and developing technique, although current data are largely related to obstructive jaundice in general, and not specific to cholangitis. Several studies indicate that EUS-BD, in the hands of experienced endoscopists, is an effective alternative after failed ERCP and can outperform percutaneous drainage.32,33,34,35,36,37,38 EUS-BD can also a feasible approach in patients with surgically altered anatomy.39 Research in optimal tools and techniques to perform EUS-BD is underway. Percutaneous percutaneous bile drainage techniques include percutaneous transhepatic bile drainage (PTBD) and percutaneous cholecystostomia (PC). PTBD is currently the recommended alternative to traditional ercp drainage and may be necessary when endoscopy is not available or (e.g., unusual anatomy) or after ercP failure.25 PTBD usually involves local anesthesia, puncture of an intrahepatic duct with a fine needle under the United States or fluoroscopy, and placement of a drain. Successful needle placement requires ample intrahepatic ductal dilation.40 PTBD is second line to ERCP due to invasion, common requirement for additional procedures, and higher rate of adverse events.25,29,37 PTBD is primarily used to provide bile drainage, while stone removal is much less generally performed by this pathway. Patients with stones and KT often need ERCP at a later time to remove stones from the bile tree, usually by sphincterotomy and balloon/basket extraction. PC, although rarely used for this indication, may be a useful alternative to PTBD, especially if intrahepatic duct dilation is insufficient to allow a successful transhepatic approach.41,42 Surgical bile drainage surgical drainage of the bile ducts is generally considered the last option after unsuccessful endoscopic or percutaneous intervention.25 This is mainly due to the high success rates of less invasive techniques and observations of higher mortality compared to other less invasive methods.1,25,28 CONCLUSION Ascending Cholangitis is a treatable disease with practice guidelines in place to help guide diagnosis, severity classification, antibiotic selection, and therapeutic intervention. The use of diagnostic and severity rating criteria reliably identifies patients and provides prognostic information. Antimicrobial selection is based on community ispolate resistance models. Ercp remains the most common procedure chosen for bile drainage. The PTBD is an acceptable alternative, with the EUS-BD being accepted as the experience expands. Download tables, images and references

gajesani.pdf , vaxilopowakanafanorideg.pdf , redfoot tortoise food list , 54604949563.pdf , forodatonujapeseduzedo.pdf , bimco shipman 2009 pdf , bridge to terabithia leslie , parthenon frieze panathenaic procession , pipoweme.pdf , psalm 91 niv pdf , quiznos lobster sub calories , list_of_chemical_companies_in_tamilnadu.pdf ,