



**Information for the treating physician:**

If you have received this card from a patient, you may be looking at the following: Biliary obstruction in a patient with Cholangiocarcinoma (bile duct cancer).

Ascending cholangitis is a common complication in a patient with a bile duct drainage tube or biliary stent, but can occur with any patient with cholangiocarcinoma. Cholangitis can be life threatening and should warrant admission to a hospital and be treated as a medical emergency. Other rare but serious complications seen in these patients are acute cholecystitis and liver abscess.

Please try to contact the patients' medical/surgical oncologist or gastroenterologist first. **If you are unable to contact the treating doctor(s)** please continue reading below for general guidelines on: symptoms, signs, labs, workup and treatment for this patient.

**Cause:** In patients with biliary cancer, the instrumented bile duct and the bile duct drainage tube are at high risk for infection. Obstruction due to sludge or tumor ingrowth without infection is far less common. Gram negative bacilli are the most common organisms, sometimes gram positive enterococci may be the cause.

**Symptoms:** Patients present with fever, shaking chills, abdominal pain, jaundice, malaise and general weakness.

**Signs:** Fever, jaundice, right upper quadrant tenderness, some patients may present with hypotension and septic shock.

**Labs:** Elevated WBC (may not be present if patient is currently on chemotherapy), elevated bilirubin, alkaline phosphatase, or just elevated AST, ALT if the patient presents early.

**Workup:** Routine blood work, blood cultures, culture from PTC tube if present and USG or CT of abdomen

**Treatment:**

*All patients presenting with the above should receive: IV fluids, admission, antibiotics, GI consult for ERCP.*

*Unstable patients:* Aggressive supportive measures, broad spectrum antibiotics that cover gram negatives, add aminoglycoside if patient is in septic shock and call gastroenterologist for urgent ERCP. Interventional radiology may need to drain abscess, or insert cholecystostomy tube. Patients with PTC tubes may require an IR consult for a cholangiogram that both flushes and verifies adequate drainage with a tube change, if indicated. Antibiotics should be continued for 7-10 days and may be switched to cephalosporins if appropriate.

*Stable patients:* ERCP within 24- 48 hours is needed as this is the definitive treatment. Antibiotics should be given for 7-10 days, could be switched to cephalosporin if appropriate.

Contact the patients' surgical or medical oncologist and/or gastroenterologist for guidance on management and follow-up on cultures.