

# Gallstones — when to refer, when not to refer, and when to refer urgently

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v1.0

Don't refer	Refer (routine)	Refer urgently
MANAGE IN PRIMARY CARE	ELECTIVE PATHWAY	TIME-CRITICAL
<p><b>Asymptomatic gallstones, normal gallbladder</b> Reassure. Only 1–2% per year become symptomatic. No imaging follow-up. NICE CG188</p>	<p><b>True biliary colic</b> Episodic, severe, post-prandial RUQ/epigastric pain. 30 min to a few hours, settles completely. Radiates to back or right shoulder. Well between attacks. <i>Refer for elective lap chole — recurrence is the rule.</i></p>	<p><b>Acute cholecystitis</b> <span style="background-color: #f44336; color: white; padding: 2px;">SAME-DAY</span> RUQ pain &gt;24 h, fever, Murphy's sign, raised WCC/CRP, USS thick-walled GB ± pericholecystic fluid. Surgical assessment — <b>not co-amoxiclav from home</b>. Early lap chole within 1 week (NICE) / 72 h of onset (AUGIS). <i>"Cool down, return at 6 weeks" is obsolete.</i></p>
<p><b>Polyps ≤5 mm, no risk factors</b> No follow-up. ESGAR 2022</p>	<p><b>Polyps ≥10 mm, or 6–9 mm with risk factors</b> Risk factors: age &gt;60, PSC, Asian ethnicity, sessile polyp (incl. focal wall thickening &gt;4 mm). 6–9 mm without RFs → USS surveillance at 6, 12, 24 months. ESGAR 2022</p>	<p><b>Ascending cholangitis</b> <span style="background-color: #f44336; color: white; padding: 2px;">EMERGENCY</span> Charcot's triad: RUQ pain + jaundice + fever. Reynolds' pentad adds hypotension and confusion (peri-arrest). Blue-light admission. CBD clearance within 24 h.</p>
<p><b>Chronic non-specific RUQ pain — normal scan, normal LFTs</b> Re-characterise the pain. Think dyspepsia, IBS, abdominal wall pain (Carnett's sign), MSK, fatty liver, right colon. <i>If concern persists → gastroenterology, not surgery.</i></p>	<p><b>Resolved transient jaundice with stones on USS</b> <span style="background-color: #ffc107; padding: 2px;">URGENT ROUTINE</span> + MRCP. Passed CBD stone until proven otherwise — next stone may cause cholangitis or pancreatitis.</p>	<p><b>Gallstone pancreatitis</b> <span style="background-color: #f44336; color: white; padding: 2px;">EMERGENCY</span> Epigastric pain radiating to back, vomiting, raised amylase/lipase. Emergency admission.</p>
<p><b>Mildly deranged LFTs, no biliary features</b> Work it up as deranged LFTs, not gallstones. Standard panel: bilirubin, albumin, ALT, ALP + FBC. Hepatocellular pattern → NAFLD, alcohol, viral, autoimmune, drug. BSG 2018</p>	<p><b>Functional gallbladder disorder</b> Typical biliary pain with normal USS. Refer for HIDA with CCK; counsel ~60–70% respond to surgery.</p>	<p><b>Painless obstructive jaundice, age ≥40</b> <b>2WW pancreatic cancer pathway, NOT gallstone clinic.</b> Pancreatic head cancer until proven otherwise — even with known stones. Upper abdominal mass → urgent direct-access USS within 2 weeks. NICE NG12</p>
<p><b>The GGT one-liner</b> <b>Raised ALP + raised GGT = biliary.</b> Raised ALP + normal GGT = not the liver (think bone, Paget's, vit D, pregnancy).</p>	<p><b>Late post-cholecystectomy symptoms</b> Months to years post-op. Re-refer with MRCP. <i>(Early post-op symptoms — see right.)</i></p>	<p><b>Marked LFT derangement / synthetic failure</b> Same-day medical/hepatology. Falling albumin, rising INR, encephalopathy. <i>Liver failure pathway, not gallstone pathway.</i> BSG 2018</p>
	<p><b>Discuss with surgery (case-by-case)</b> Stones &gt;3 cm; porcelain GB (modern data ~6% cancer risk only); sickle cell disease; pre-bariatric. <b>Diabetes is no longer an indication.</b></p>	<p><b>Early post-cholecystectomy complications</b> Days to weeks post-op = bile leak or retained stone. Urgent re-referral to operating team.</p>

<p><b>KEY POINTS</b></p> <ul style="list-style-type: none"> <li>→ <b>Stones on USS are common</b> — they're not always the cause of the pain.</li> <li>→ <b>Pregnancy: lap chole in any trimester</b> for symptomatic disease (SAGES 2024). The "second trimester only" rule is obsolete.</li> </ul>	<ul style="list-style-type: none"> <li>→ <b>Painless jaundice ≥40 = pancreas</b>, not gallbladder, until proven otherwise.</li> <li>→ <b>A good referral characterises the symptoms</b>, not just the scan: USS detail, LFT trend, BMI, fitness for GA.</li> </ul>
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<p>REFER TO <a href="mailto:aly.admin@lips.org.uk" style="color: white; text-decoration: none;">aly.admin@lips.org.uk</a></p>	<p>INFORMATION &amp; RESOURCES <a href="http://mohamedaly.co.uk" style="color: white; text-decoration: none;">mohamedaly.co.uk</a></p>	<p><b>Mr Mohamed Aly</b> Consultant Upper GI &amp; General Surgeon</p>
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**EVIDENCE BASE**  
NICE CG188 Gallstone disease (2014, surveillance 2018) · NICE NG12 Suspected cancer (Jan 2026) · Newsome PN et al. BSG abnormal liver blood tests. Gut 2018;67:6–19 · Foley KG et al. ESGAR/EAES/EFISDS/ESGE gallbladder polyp guidelines, Eur Radiol 2022;32:3358–68 · Beekingham I et al. AUGIS Pathway for Acute Gallstone Diseases 2015 · SAGES guidelines for laparoscopy during pregnancy, Surg Endosc 2024