**Cholangitis**

Inflammation involving the hepatic and common bile ducts

Pathogenesis similar to that of cholecystitis: obstruction of common bile duct oedema, congestion, necrosis of walls  bacterial proliferation within biliary tree.

**Causes of obstruction:**

- gallstones

- biliary tract surgery, tumour, parasitic infection, calcific pancreatitis etc.

**Etiology:**

Obstruction of the common bile duct due to gallstones

Benign strictures

Malignant strictures

Sclerosing cholangitis

Parasites

Clinical Presentations:

High fever

RUQ pain

Jaundice (usually prominent(

Charcot’s triad: present in 85% cases

Chills, rigors

RUQ tenderness, pale stools

Sepsis, septic shock

Charcot’s Triad

Jaundice, fever, and RUQ pain

Reynold’s Pentad

Addition of altered mental status, and hypotension

**Risk Factors:**

Age > 50 years

Cholelithiasis (formation of gallstones)

Benign strictures

Malignant strictures

Postprocedure injury of bile ducts

History of sclerosing cholangitis

**Complications:**

* Bacteraemia (about 50% cases)
* Liver abscesses
* Septic shock

**Diagnosis:**

* Marked leukocytosis
* Marked ↑ bilirubin, alk phosphatase; moderate ↑ transaminases
* Blood cultures:

- enteric GNB and anaerobes most frequently isolated.

* Imaging studies:

- ultrasound; CT scan

- ERCP (endoscopic retrograde cholangio-pancreatography), PTC (percutaneous transhepatic cholangiography)

**Treatment:**

* Prompt institution of appropriate antimicrobial therapy essential:

- initial choice usually empirical

- eg. 3rd gen cephalosporin/quinolones/co-amoxiclav + metronidazole.

* Biliary drainage
  + ERCP
  + Percutaneous transhepatic cholangiography (PTC)
  + EUS guided drainage
  + Open surgical drainage