Obstructive Jaundice

**Differentiate:**
Intrahepatic vs. *Extrahepatic Cholestasis* = obstructive jaundice (“medical” vs. “surgical”)
- Biliary obstruction further characterized by the **level of obstruction:**
  - *Intrahepatic / Extrahepatic* biliary dilation: above/below the liver hilum or both

**Key Clinical Points:**
- **Pain** in intrahepatic cholestasis - variable, vague, dull, mild, non radiating; liver capsule stretch
- **Pain** in obstructive jaundice - epigastric/RUQ, radiation to scapula, R shoulder, severe acutely
- **Pruritis** - intrahepatic cases such as PBC may precede clinical jaundice related to bile acids
- In extrahepatic biliary obstruction: associated with overt jaundice
- **Stool** - extrahepatic: pale or clay color; oily, features of steatorrhea
- **Acuity** - depends on etiology acute such as w/ CBD stone to insidious with pancr/biliary cancer
- **Fever/Sepsis** - biliary obstruction associated with cholangitis
- **Prior/recent Biliary intervention** - altered anatomy, obstructed drainage of contaminated bile

**Differential Diagnosis / clinical clues: Extrahepatic Cholestasis (Biliary Obstruction):**
- **Choledocholithiasis** (CBD stone)
- **CBD stricture:** post op (post lap choley - clips or cautery), chronic pancreatitis, papillary stenosis, SOD dysfunction, ischemia (hepatic a)
- **Neoplasm:** pancreatic, cholangiocarcinoma/ampullary carcinoma
- **Extrinsic:** lymph nodes, tumor, Mirizzi’s Syndrome (stone in GB neck/inflammation), biloma
- **Congenital/anatomic:** choledochal cysts, biliary atresia
- **Infections:** HIV cholangiopathy: parasites; (ascaris, oriental cholangiohepatitis)
- **Autoimmune:** PSC (70% with concurrent IBD); Autoimmune Pancreatitis (IgG4 assoc. dz)
- **Mimics:** acute cholecystitis, medical/intra-hepatic disease such as alcoholic or viral hepatitis
  - **HIGH risk if operated:** paraneoplastic syndromes, drug toxicity, autoimmune hepatitis

**Diagnostic Approach:**
- **Ultrasound** as a screen for biliary dilation, gallstones; **CT scan** is complementary, adj lesions
- If no biliary dilation or clinical suspicion: exclude **medical/intrahepatic** causes of cholestasis

**Direct biliary imaging** - depends on local expertise, patient stability, prob of biliary intervention
- **MRI/MRCP** - bile remains sterile, imaging of intra & extra-hepatic biliary system
- **EUS** - expertise required, +/- limited to extra-hepatic biliary system; option to ERCP/ES/stent
- **PTC** - invasive, requires dilated intrahepatic ducts, useful to drain obstructed biliary system or “rendezvous” with ERCP to cross/access/stent a biliary stricture
- **ERCP** - if therapeutic intervention is probable and outweighs risk of pancreatitis, morbidity

**Management:**
Urgency of biliary decompression related to etiology - emergent if cholangitis/sepsis
CBD stones - ERCP with sphincterotomy(ES) /stone extraction; Lap choley
Mirizzi Syndrome - cholecytectomy
Strictures - ERCP based dilation w/ ES; if refractory/not amenable - hepatico-jejunostomy
Pancreatic/ampullary/cholangio carcinoma - surgery, typically Whipple procedure
PSC - stent, antibiotics, liver transplantation
Extrinsic compression - treat underlying process.
Autoimmune Pancreatitis - steroids

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MRCP

ERCP