Blunt abdominal trauma in adult (excluding penetrating trauma and paediatric trauma)

**Unstable**
- FAST +/- CXR, KUB
  - Free intra-abdominal fluid: Surgery
  - No intra-abdominal fluid: Clinical management

**Stable**
- High suspicion of intra-abdominal injury
  - CT abdomen and pelvis +/- thorax
    - No intra-abdominal injury: Clinical management
    - Intra-abdominal injury (except renal or urinary tract injury)
      - Angiogram ± embolization
      - Surgery
      - Please refer to guidelines on renal trauma (UR1) and lower urinary tract injury (UR2)
  - Low suspicion of intra-abdominal injury
    - Clinical management

**Follow the “stable” pathway**
- Observation
  - Failure: Surgery
  - Observation
  - Failure: Surgery

**Stabilize**
- Look for other causes of hypoperfusion
  - Stabilize
  - Failure: Follow the “stable” pathway
REMARKS

1 **General**
   1.1 Penetrating trauma and paediatric trauma are excluded in this guideline.
   1.2 The extent and choice of imaging is influenced by the haemodynamic stability of the patient together with the severity of trauma, site of trauma, and other associated injuries.

2 **Plain radiograph**
   2.1 Plain radiographs including chest X-ray (CXR) and kidney, ureter and bladder radiograph (KUB) can evaluate fracture, pneumothorax, pneumomediastinum, and abnormal intra-abdominal gas collection, but they are frequently negative.
   2.2 CXR, KUB and focused assessment with sonography for trauma (FAST) are complementary examinations if patient condition permits.

3 **US**
   3.1 US is not an appropriate modality to evaluate organ injury in a patient with blunt abdominal trauma. A negative US does not rule out visceral injury.
   3.2 FAST is to check for intra-abdominal free fluid that can guide decisions on further management.
   3.3 A negative FAST does not completely rule out haemoperitoneum. There is a false negative rate of >15%.

4 **CT**
   4.1 In stable patients with blunt abdominal trauma, CT abdomen and pelvis is the primary imaging modality for deciding whether the patient needs urgent surgery, angiography +/- therapeutic embolization, or close observation.
   4.2 CT is excellent for identifying active haemorrhage, or hepatobiliary, splenic, pancreatic, genitourinary, intestinal, or diaphragmatic injury.
   4.3 CT evaluation of abdomen and pelvis for blunt trauma does not require the use of oral contrast. Scanning should include the lower thorax through to the floor of the pelvis with administration of intravenous (IV) contrast.

5 **Angiography**
   5.1 Not appropriate as an initial imaging modality. It is appropriate if additional clinical information or imaging suggests possibility of active haemorrhage or pseudoaneurysm in haemodynamically stable patients.

REFERENCES

Blunt trauma in adult with clinical suspicion of pelvic fracture

AP pelvic radiograph, +/- FAST

FAST +ve or suspected intra-abdominal injury

Haemodynamically unstable (despite mechanical stabilisation)

- External fixation
- Preperitoneal packing
- Pelvic angiogram +/- embolization

Stabilize

CT pelvis +/- abdomen

Haemodynamically stable

Unstable pelvic fracture

- CT pelvis +/- abdomen
- Surgery and fixation
- +/- Pelvic angiogram & embolization

Stable pelvic fracture

- Observation
- +/- CT pelvis
- +/- Pelvic angiogram & embolization

Please refer to guideline on blunt abdominal trauma in adult (GI 1)
REMARKS

1 General
1.1 The clinical management of pelvic trauma is dependent on the haemodynamic status and the amount of blood loss.
1.2 Concomitant major trauma to other sites has to be excluded in significant pelvic trauma.
1.3 Unstable fracture includes rotationally unstable or vertically unstable fractures, please refer to Young and Burgess Classification.

2 Plain radiograph
2.1 Anterior-posterior (AP) radiograph of the pelvis is recommended in patients with high clinical suspicion of pelvic fracture.
2.2 Additional images, such as pelvic inlet or outlet views, need not be obtained in acute phase of injury.
2.3 Plain radiograph can underestimate the extent of bony injury and fracture pattern on plain radiograph does not predict haemorrhage or the need for angiography.

3 CT
3.1 CT pelvis is required for haemodynamically stable patients with high-energy pelvic injuries or disruption of pelvic ring.
3.2 CT is useful in pre-operative planning of pelvic, sacral and acetabular fractures. 2- and 3-dimensional reformats are useful in selected cases.
3.3 CT abdomen and pelvis should be done if intra-abdominal and pelvic injuries are suspected.

4 Angiography
4.1 Angiography with pelvic embolization is useful in patients with pelvic fractures who are haemodynamically unstable.
4.2 Patients with evidence of contrast extravasation in pelvis on CT may require pelvic angiography and embolization regardless of haemodynamic status.

REFERENCES
Suspected pneumoperitoneum

Plain radiograph, preferably erect CXR or left lateral decubitus AXR

- Free air demonstrated
  - Urgent management
- Equivocal finding
  - CT scan
REMARKS

1  Plain radiograph
   1.1 Erect chest X-ray (CXR) is used to detect subphrenic gas.
   1.2 Left lateral decubitus abdominal X-ray (AXR) also helps to demonstrate free air, especially in ill patients who cannot sit or stand.

2  CT
   2.1 CT is useful for clarification of equivocal finding on plain radiograph.

REFERENCES

Dysphagia

Clinical history and physical examination

Oropharyngeal dysphagia

- With attributable cause, e.g. stroke: VFSS
- Without attributable cause: Endoscopy and/or barium swallow

Retrosternal dysphagia

- Endoscopy and/or barium swallow
  - No structural abnormality: Suspected functional abnormality
  - Structural abnormality: Manage accordingly, e.g. CT for staging malignancy

- Manage accordingly, e.g. CT for staging malignancy

VFSS

Manometry
REMARKS

1 General
1.1 Dysphagia can be classified by level (oropharyngeal or retrosternal) and aetiology (structural or functional).
1.2 Careful history taking often helps to differentiate the level of dysphagia and provides clues about the underlying aetiology, especially for oropharyngeal dysphagia.
1.3 Abnormalities of mid & lower oesophagus to gastric cardia may cause referred dysphagia to upper chest or pharynx. Therefore, the oesophagus and gastric cardia should also be assessed in patients with oropharyngeal dysphagia without attributable causes.

2 Barium swallow
2.1 Barium swallow and endoscopy are complementary to each other in assessing oesophageal strictures and tumours.
2.2 The length and the severity of stenosis are well demonstrated on barium swallow.
2.3 Barium swallow can detect motility disorders and it may be more sensitive to detect certain structural abnormalities such as oesophageal webs and rings.
2.4 Endoscopy allows biopsies to be taken and is more sensitive to detect mild reflux oesophagitis or other subtle oesophagitis.

3 Video-fluoroscopic swallowing study (VFSS)
3.1 VFSS focuses on evaluating the oral cavity, pharynx and cervical oesophagus to access for oral and pharyngeal swallowing phase abnormalities.

4 CT
4.1 CT can be used to assess extrinsic lesions and for tumour staging prior to surgery.

REFERENCES

GI 5 Acute gastrointestinal bleeding

Clinical history and physical examination

Haematemesis
- Endoscopy
  - Diagnosis: Indeterminate
  - Treatment: Bleeding ongoing
    - Angiography / CTA abdomen
  - Treatment: Bleeding stopped

Melaena
- Endoscopy
  - Diagnosis: Indeterminate
  - Treatment: Bleeding ongoing
    - CTA abdomen
  - Treatment: Bleeding stopped

Fresh blood per rectum
- Sigmoidoscopy ± colonoscopy
  - Diagnosis: Indeterminate
  - Treatment: Bleeding ongoing
    - RBC scan
    - Angiography
  - Treatment: Bleeding stopped

Haematemesis
- Endoscopy
  - Diagnosis: Indeterminate
  - Treatment: Bleeding ongoing
    - Angiography / CTA abdomen
  - Treatment: Bleeding stopped

Melaena
- Endoscopy
  - Diagnosis: Indeterminate
  - Treatment: Bleeding ongoing
    - CTA abdomen
  - Treatment: Bleeding stopped

Fresh blood per rectum
- Sigmoidoscopy ± colonoscopy
  - Diagnosis: Indeterminate
  - Treatment: Bleeding ongoing
    - RBC scan
    - Angiography
  - Treatment: Bleeding stopped

Capsule endoscopy / Balloon assisted endoscopy / CT enterography / Small bowel enema / RBC scan / Meckel’s scan
**REMARKS**

1. **Plain radiograph**
   1.1 Abdominal X-ray (AXR) is of no value in diagnosing acute gastrointestinal (GI) bleeding.

2. **Small bowel study**
   2.1 Small bowel barium studies may detect Meckel’s diverticulum or small bowel tumours. If both small bowel study and angiography are required for investigation of acute GI bleeding, angiography should be performed first.

3. **Nuclear medicine**
   3.1 Technetium-99m (Tc-99m) labelled red blood cell (RBC) scan
      3.1.1 It is indicated primarily for overt mid or lower GI bleeding.
      3.1.2 It is also helpful in identifying the source of obscure GI bleeding.
      3.1.3 It can detect a bleeding rate as low as 0.05-0.1ml/min and can help to localize the bleeding site, but errors in localization occur in cases of gastric or duodenal source.
      3.1.4 It can localize intermittent bleeding.
   3.2 Meckel’s scan
      3.2.1 In a young patient with lower GI bleeding, Meckel’s diverticulum has to be considered.

4. **CT abdomen (CT angiography & CT enterography)**
   4.1 In upper gastrointestinal bleeding (UGIB), it is useful for localizing obscure UGIB, and for work-up in patients with UGIB with prior history of aortic reconstruction or pancreaticobiliary procedure.
   4.2 In lower gastrointestinal bleeding (LGIB), it can be used to localize LGIB, identify the pathological causes and direct treatment, as well as provide arterial anatomy for treatment planning.
   4.3 CT enterography or CT enteroclysis is the choice in obscure LGIB when capsule endoscopy is contraindicated, e.g. suspected obstruction or suspected stricture.

5. **Angiography**
   5.1 For bleeding to be detected on angiography, it must be active arterial or capillary bleeding, with rate greater than 0.5 ml/min. It is usually not useful in venous bleeding.
   5.2 The bleeding site can be localized on angiography, and in selected cases, vasopressin infusion or embolization can be used to arrest the bleeding.
   5.3 Roles in UGIB
      5.3.1 In active UGIB when upper endoscopy is unable to control or localize the bleeding source, or when re-bleeding occurs, or when the patient is haemodynamically unstable.
   5.4 Roles in LGIB
      5.4.1 In massive LGIB with haemodynamic instability or heavy transfusion need;
      5.4.2 Also allows treatment by means of embolization.

**REFERENCES**

**GI 6 Chronic recurrent gastrointestinal bleeding**

Chronic recurrent gastrointestinal bleeding

Positive faecal occult blood

Colonoscopy

**Further tests**
- Upper endoscopy
- Repeat colonoscopy

**Diagnosis**

**Investigation of small bowel:**
- Capsule endoscopy
- CT enterography
- CT enteroclysis

**Other alternatives:**
- CT angiography of abdomen
- Small bowel enema
- Meckel’s scan (young patients)
- Angiography if massive bleeding

**Diagnosis**
REMARKS

1 Barium enema
   1.1 Vascular lesions such as angiodysplasia may not be detected on barium enema.

2 Small bowel study
   2.1 Small bowel enema is preferred to follow through study. The diagnostic yield of follow through study is low.
   2.2 Meckel’s diverticulum and small bowel tumours might be detected on small bowel study.

3 Nuclear medicine
   3.1 Meckel’s scan
      3.1.1 In a young patient with chronic recurrent gastrointestinal bleeding, Meckel’s diverticulum has to be considered.

4 CT enterography or CT enteroclysis
   4.1 There is no consensus on the diagnostic algorithm for the investigation of small bowel bleeding after exclusion by upper endoscopy and colonoscopy. Capsule endoscopy is generally regarded as the first line investigation.
   4.2 CT enterography or CT enteroclysis are alternatives, especially in patients with contraindications to capsule endoscopy such as:
      4.2.1 Suspected obstruction
      4.2.2 Suspected stricture

5 CT angiography of abdomen
   5.1 CT angiography of abdomen is useful in patients with active bleeding, chronic bleeding not localized by other means, for diagnosing underlying pathological causes and vascular causes, and for planning angiography and endovascular intervention.

6 Angiography
   6.1 Catheter angiography is helpful in conditions of massive gastrointestinal bleeding and chronic bleeding not localized by other means; it can provide treatment by means of embolization.

REFERENCES

Small bowel obstruction

Clinical history and physical examination

Acute or high grade

- AXR

  - Diagnosis
    - CT abdomen and pelvis / MRI abdomen and pelvis / small bowel follow-through
  - Treatment

Recurrent or low grade

- AXR

  - Diagnosis
  - Indeterminate
    - CT abdomen and pelvis, CT/MRI/Fluoroscopic enteroclysis, CT/MRI enterography, small bowel follow-through
  - Treatment
REMARKS

1 Plain radiograph
   1.1 Often the first line investigation to detect the presence of obstruction.¹
   1.2 Useful to establish if bowel obstruction is high or low grade.²
   1.3 For patients in whom a strong clinical suspicion of small bowel obstruction is present, consideration should be given to immediate cross-sectional imaging, particularly CT.³

2 CT
   2.1 Standard CT, performed with an intravenous (IV) contrast if possible, but generally without oral contrast, is the primary imaging modality for evaluating small bowel obstruction and should be strongly considered in the initial evaluation of patients with suspected high-grade small bowel obstruction.³
   2.2 When abdominal X-ray (AXR) is equivocal and low-grade, and subacute small bowel obstruction is suspected clinically, CT enteroclysis has a higher site-specific sensitivity and specificity than standard CT.²

3 Small bowel study
   3.1 In suspected small bowel obstruction due to adhesions, presence of water-soluble contrast in the colon on a plain radiograph obtained 24 hours after oral administration of 100 ml water-soluble contrast medium is a good predictor of resolution without operation.²
   3.2 Fluoroscopic small bowel examinations play a much less substantial role and should not be used as a primary imaging modality in diagnosing an acute small bowel obstruction.³
   3.3 If intermittent, recurrent, or low-grade small bowel obstruction is a primary concern, an enteroclysis is likely the next best test.³

4 MRI
   4.1 Children and in particular pregnant patients with known or suspected small bowel obstruction, as well as younger patients with repeated episodes of obstruction, are the ideal population to undergo MRI. In pregnant patients, only non-contrast sequences are obtained. In non-pregnant individuals, sequences with or without IV gadolinium contrast can be performed.³

REFERENCES

GI 8  Large bowel obstruction

Large bowel obstruction

Clinical history and physical examination
  Supine AXR ± erect AXR

  Diagnosis established
e.g. colonic volvulus

  Indeterminate

  Suspected mechanical causes
  Colonoscopy + biopsy
  +/- Contrast enema

  Suspected adynamic ileus
  Contrast enema

  Mechanical

  Functional obstruction

  +/- CT
Gastrointestinal Radiology

GI 8  Large bowel obstruction

REMARKS

1  Plain radiograph
   1.1 When acute large bowel obstruction is suspected, abdominal X-ray (AXR) may be used as an initial examination to help establish the diagnosis and to indicate the likely level.¹
   1.2 Erect AXR is not indicated routinely. It may be taken when supine AXR is normal but there is strong clinical suspicion of bowel obstruction.

2  CT
   2.1 CT is the investigation of choice after AXR. It will confirm the diagnosis, delineate the level of acute large bowel obstruction and can also identify the cause.²
   2.2 CT is also used for evaluation of extrinsic lesions and for staging of confirmed carcinoma.

3  Contrast enema
   3.1 Helps to exclude pseudo-obstruction.
   3.2 May consider it for problem solving if CT is not available or equivocal.¹

REFERENCES

GI 9  Palpable abdominal mass

Clinical history and physical examination
± supine abdominal X-ray

Upper abdomen
Gastrointestinal
Barium meal / endoscopy
± CT/MRI

Iliac fossa
Gastrointestinal
US
Small bowel study
Further tests:
• Colonoscopy
• ± Barium enema
• ± CT/MRI

Pelvis
Gastrointestinal
CT ± MRI
± Barium enema ± CT/MRI
US/CT ± MRI

Others

Gastrointestinal
Others

Others
REMARKS

1  General
   1.1 The choice of examination depends on the symptoms and the organs suspected to be abnormal.
   1.2 US and CT should precede barium studies to avoid barium related artefacts.

2  Plain radiograph
   2.1 Plain radiograph is of limited value.

3  Fluoroscopy
   3.1 Request should clearly indicate areas of interest so that the most appropriate studies can be employed, e.g. small bowel enema for small bowel lesions.

4  US
   4.1 US is useful in hepatobiliary system, kidneys and female pelvis but may be limited by bowel gas in both iliac fossae.

5  CT
   5.1 CT is a useful alternative to US to exclude a lesion especially in obese patients and to provide excellent survey of the abdominal organs and retroperitoneum.

6  MRI
   6.1 MRI may be used to evaluate complex lesions not definitely characterized by US or CT. ²

REFERENCES

GI 10  Suspected liver mass in cirrhotic patients

Nodule detected by US

Dynamic CT/MRI

Early-phase contrast enhancement

Delayed-phase washout

No delayed-phase washout

No early-phase contrast enhancement

Tumour diameter > 1.5cm?

Yes

No delayed-phase washout

No early-phase contrast enhancement

No lesions

Increase in size / increase in tumour marker levels

No

Tumour diameter > 1cm?

Yes

No

Optional testing
- Hepatocyte-specific contrast enhanced MRI, diffusion weighted MRI
- PET-CT
- Contrast-enhanced US
- CT angiography
- Liver tumour biopsy

Definitive diagnosis of hepatocellular carcinoma

Hepatocellular carcinoma

* 3rd JSH HCC Evidence-based guidelines recommend 3 months interval. Actual time interval for investigation and choice of tests will vary between hospitals depending on resources and machine availability.
REMARKS

1 General
   1.1 Radiological investigations are essential in detecting hepatomegaly (and its cause) and liver masses. It is useful in differentiating benign and malignant hepatic lesions and in assessing the resectability of liver tumours.
   1.2 The American Association for the Study of Liver Disease (AASLD) and European Association for the Study of Liver (EASL) guidelines propose a diagnostic algorithm starting from the tumor size, whereas the Asian Pacific Association for the Study of the Liver (APASL) and Japanese Society of Hepatology (JSH) guidelines recommend an algorithm starting from arterial tumour vascularity (hyper- or hypovascular in the arterial phase).

2 US
   2.1 US is the best initial imaging modality as it is non-invasive and sensitive in detecting liver lesions. It is a screening test and not a diagnostic test for confirmation.
   2.2 Contrast-enhanced US is considered as sensitive as dynamic CT or MRI in the diagnosis of hepatocellular carcinoma (HCC).

3 CT and MRI
   3.1 Dynamic CT or MRI is recommended as a first-line diagnostic tool for HCC when a screening test result is abnormal.
   3.2 Hallmark of HCC during CT or MRI is the presence of arterial enhancement, followed by washout of the tumour in the portal-venous and/or delayed phases. The AASLD and EASL guidelines accept only four-phase CT and dynamic contrast MRI for HCC diagnosis, whereas the APASL and JSH guidelines also accept contrast-enhanced US.
   3.3 Various studies have verified the usefulness of liver specific contrast enhanced MRI. It is included in the Japanese Society of Hepatology Liver Cancer Study Group 2014 Surveillance and Diagnostic Algorithm of HCC.

4 Nuclear Medicine
   4.1 Fluorodeoxyglucose (FDG) PET has limited sensitivity for well differentiated HCC. Its low sensitivity is due to low uptake in well-differentiated HCC. However, focal FDG hypermetabolism in liver suggests high likelihood of malignancy (primary or secondary). False positive includes liver abscess.
   4.2 For identification of intrahepatic HCC lesions, limited evidence found PET with C-11 acetate and other alternative tracers such as F-18 fluorocholine and F-18 fluorothymidine have substantially higher sensitivity than F-18 FDG PET. Currently PET is not a routine diagnostic tool according to most of the international guidelines.
   4.3 F-18 FDG PET-CT was useful in ruling in extrahepatic metastases of HCC and valuable for ruling out recurrent HCC.
   4.4 Tc-99m sulfur colloid scintigraphy (+/- Tc-99m mebrofenin scintigraphy) is helpful in differentiation of focal nodular hyperplasia from other hepatic lesions that do not contain Kupffer cells (e.g. hepatic adenoma and HCC).
5 Angiography

5.1 Angiography does not assume a major diagnostic role in modern liver imaging and is superseded by CT and MRI.
REFERENCES

Jaundice in adult

Clinical history, physical examination and laboratory tests

Haemolytic disorders

Dilated ducts

No obstruction:
- Post-cholecystectomy
- Elderly

With obstruction:
- Luminal
- Mural
- Extramural

Hepatobiliary diseases

No dilated ducts

Strong suspicion of obstruction:
- Early obstruction with small stone
- Sclerosing cholangitis

Liver disease

± Liver biopsy

CT / MRI (including MRCP) / ERCP / PTC / Endoscopic US / Cholescintigraphy

Ref 6,7,8
REMARKS

1 US
   1.1 US is a non-invasive, accurate and reliable technique for assessing the gallbladder, common bile duct and intrahepatic ducts, and should be employed as the primary investigation for evaluating the biliary system. It is also valuable in the detection of liver diseases.
   1.2 US detection of pancreatic lesion is less reliable in certain patients, mainly due to overlying bowel gas.

2 Nuclear medicine
   2.1 In very early biliary obstruction, nuclear medicine may be useful as US may not detect abnormality in the liver. Alternatively, a repeat US may show progressively dilated bile ducts. US is preferred as the initial screening test to provide anatomic details of the bile ducts.
   2.2 Hepatobiliary scintigraphy provides a non-invasive method for evaluation of biliary system patency.

3 CT
   3.1 CT is indicated when tumour is suspected and when US is inadequate.
   3.2 It is very sensitive in detecting gallstones, air in the biliary tree and extrahepatic lesions obscured by bowel gas on US.

4 MRI
   4.1 MRI can demonstrate both the site and cause of biliary obstruction. For detection of ductal calculi, magnetic resonance cholangiopancreatography (MRCP) is the most sensitive non-invasive technique.

5 Cholangiography
   5.1 Cholangiography by endoscopic retrograde cholangiopancreatography (ERCP) or percutaneous transhepatic cholangiogram (PTC) is the definitive imaging modality in the assessment of the biliary tree but both are invasive. ERCP is better for low obstruction while PTC is more reliable for high obstruction.
   5.2 Due to significant advances in cross-sectional imaging, in particular the advent of MRCP, ERCP currently has an almost exclusively therapeutic role. The main indication for ERCP remains management of common bile duct stones. It also remains the standard for stent placement in cases of obstructive jaundice.

6 Endoscopic US
   6.1 Endoscopic US is the most accurate method for the detection of small ductal stones and small papillary or periampullary tumours. It allows biopsy of the pancreas without risk of tumour seeding.

REFERENCES

Biliary disease in adult

Clinical history, physical examination and laboratory tests

US
Ref 1-5

Gallbladder disease

Stone

Cholecystitis

Tumour

± CT/cholecintigraphy in equivocal or complicated case
Ref 10,11,12

Bile duct disease

MRI including MRCP / ERCP / PTC
Ref 6,7

Stone or cholangitis

CT staging
Ref 8,9

Congenital anomaly

Ref 12

GI 12 Suspected biliary disease in adult
REMARKS

1 Plain radiograph
   1.1 Abdominal X-ray (AXR) is not indicated as the majority of gallstones are not radio-opaque.

2 US
   2.1 US is the initial imaging modality of choice in the work-up of suspected biliary disease as it is sensitive to diagnose gallstones and gallbladder diseases.
   2.2 Although cholescintigraphy is recognized to have a higher sensitivity and specificity, US remains the initial test of choice for imaging patients with suspected acute cholecystitis for a variety of reasons, including greater availability, shorter study time, lack of ionizing radiation, morphologic evaluation, confirmation of the presence or absence of gallstones, evaluation of intrahepatic and extrahepatic bile ducts, and identification or exclusion of alternative diagnoses.\(^\text{11}\)

3 CT
   3.1 CT plays an important role in the detection of complications of acute cholecystitis in patients who fail to improve on conventional treatment.\(^\text{10}\)
   3.2 CT also plays a role in the staging of malignant biliary disease. It has the advantage of detecting extrahepatic metastases.

4 MRI
   4.1 MRI including magnetic resonance cholangiopancreatography (MRCP) is a non-invasive method to assess the biliary tree.

5 Cholangiography
   5.1 Endoscopic retrograde cholangiopancreatography (ERCP) and percutaneous transhepatic cholangiogram (PTC) provide direct imaging of the biliary tree but are not very reliable in diagnosing gallbladder calculi. Stone extraction can be performed at the same time during ERCP.
   5.2 PTC is good for hilar ductal obstruction and its management.
6 Cholescintigraphy

6.1 Cholescintigraphy has the highest sensitivity and specificity in patients suspected with acute cholecystitis. In clinically equivocal cases, cholescintigraphy should be considered.

6.2 Cholescintigraphy is indicated in a number of hepatobiliary diseases, including: acute cholecystitis, chronic cholecystitis (with gallbladder ejection fraction calculation), functional biliary pain syndromes, sphincter of Oddi dysfunction, assessment of biliary system patency and bile leakage, liver transplant assessment etc.
REFERENCES
