AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Cholangitis and Bile Duct Obstruction

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Cholangitis and obstruction of the bile duct without gallstones is a spectrum of biliary tract infection and mechanical blockage in which **gallstones** (cholelithiasis) **have been excluded as the cause**.[1] **Biliary pathogens**, most commonly Escherichia coli, Klebsiella pneumoniae, Enterococcus faecalis, and Bacteroides species, ascend from the duodenum or seed via portal circulation, producing **infection of an obstructed biliary tree**. When stones are absent, the etiology shifts to a more insidious set of causes: malignant strictures (cholangiocarcinoma, pancreatic head cancer, ampullary tumors), benign strictures (post-surgical, post-procedural), primary sclerosing cholangitis (PSC), IgG4-related sclerosing cholangitis, or indwelling biliary-stent occlusion.[2] Cholangitis is a **time-sensitive, life-threatening emergency** that can escalate rapidly to severe **sepsis** and **septic shock**.

ICD-10 Codes:

K83.09 (other cholangitis — non-calculous, non-PSC) and **K83.1** (obstruction of bile duct without stones) each map independently to HCC 68; assign BOTH when cholangitis AND obstruction are documented together. **K83.01** (primary sclerosing cholangitis) also maps to HCC 68 with a prior formal diagnosis. AVOID **K83.0** (cholangitis, unspecified) when the cause is known — code to **K83.01** or **K83.09** instead. Code the etiology separately: **C24.0** (extrahepatic cholangiocarcinoma), **C25.0** (head of pancreas), **C22.1** (intrahepatic cholangiocarcinoma), **D89.84** (IgG4-related disease); add **R17** (jaundice), **R65.20/R65.21** (severe sepsis without/with shock), and **F05** (delirium) to document severity. CRITICAL: gallstone codes (**K80.3x** calculus with cholangitis; **K80.5x** calculus without cholangitis; **K81.x** cholecystitis) carry NO HCC in V28 — never use them once imaging excludes stones.

Prevalence and Burden: Approximately **10,000 to 200,000 cases** of acute cholangitis are diagnosed annually in the United States.[5] With appropriate biliary drainage, the mortality rate is **<10%**.[5] The average age of individuals affected is **50 to 60 years old**, and males and females are affected **equally**. Racial and insurance-based disparities compound clinical outcomes: in a US NIS analysis of 248,942 admissions (1998–2009), Black patients were **61%** more likely to die during admission than White patients (**OR 1.61**), and Medicare and Medicaid patients had significantly higher in-hospital mortality compared to privately insured patients.[7] Despite overall improvements in mortality following adoption of the Tokyo Guidelines, Black patients in a contemporary 2009–2018 NIS cohort continued to experience **40%** higher in-hospital mortality **(aOR 1.4; 95% CI 1.2–1.6)** and were significantly less likely to undergo ERCP or receive it within the recommended 48-hour window.[6]