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Recognition of the entity chronic acalcular cholecystitis as a pathologic condition dates back to at least 1926, when Whipple reported that finding in large series of cholecystectomies, since that time, a few reports have surfaced on patients who underwent surgery for chronic acalculous cholecystitis. Most reports have found the same results for relief of symptoms from this disease with cholecystectomy as did Whipple (Approximately 77%) ***(Pickelman J, 1985).***

Chronic acalculous cholecystitis particularly as a cause of chronic upper abdominal pain has been faced by two problems; difficulty in diagnosing its presence accurately before surgery, and difficulty in predicting which patients are likely to benefit from cholecystectomy ***(Yost F., 1999).***

The management of patients with persistent biliary pain without gallstones remains controversial in spite of the increase the incidence of acalculous cholecystitis ***(Yost F, 1999).***

Carllangenbuch is credited with the first cholecystectomy, and calculous cholecystitis has been universally accepted since that time as a pathological condition worthy of surgical treatment.

Patients with chronic acalculous cholecystitis present as a diagnostic dilemma and surgeons in general have been slow to recognize acalculous cholecystitis as a cause of chronic upper abdominal pain ***(Ahrendt SA, et al., 1991).***

The wide variety of diagnostic tests developed in more than 60 years since Whipple's report allowed more increase in the ability to predict pre-operatively which patients are likely to have benefit from cholecystectomy.

Traditional tests used to detect chronic acalculous cholecystitis included intravenous and oral cholangiography and ultra-sonography. Additionally, fatty meals were used in conjunction with oral chalcography to improve the ability to detect this disorder, also pacification of the gallbladder. 36 hours after administration of 10 panic acid. (Telepaque) was reported by Adams & as being very diagnostic ***(Yost 1999).***

26 of 26 patients had chronic acalculous cholecystitis and all reported relief of symptoms after cholecystectomy.

In 1970s (CCK) i.e. cholecystokinin was suggested as the needed entity to improve preoperative diagnostic accuracy ***(Mishkind MT; 1999).***

So, acalculous biliary disease may be a dynamic process that can resolve or can progress to calculous biliary disease and this leads to a dilemma with regard to treatment. However, if a patients has a classic biliary colic that is persistent and is interfering with that patients lifestyle, provided that, the results of conventional biliary tree and gastrointestinal tract studies are normal, following this, cholecystectomy can be recommended ***(Barth RA, et al., 1981).***

In 1998 Goncalves RM, reported the utilization of radionuclide imaging of the gallbladder with cholecystokinin injection to allow quantitative biliary imaging of 100 patients underwent cholecystokinin cholescintigraphy, 34 had no evidence of contraction, and 30 of these underwent cholecystectomy 10 had microscopic calculi and 20 had chronic acalculous cholecystitis and all had relief of symptoms.

Barth RA, et al., 1981 reported on 59 patients with choric acalculous cholecystitis with cholecystokinin ejection fraction of less than 50% and underwent cholecystectomy, 92% had abnormal pathology and 95% had symptom relief after surgery.