International Journal of Science and Research (IJSR)
ISSN: 2319-7064
SJIF (2022): 7.942

Incidental Gall Bladder Carcinoma in Laparoscopic Cholecystectomy - A Rare Case Report

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Abstract: ***Gall bladder cancer is most common malignancy of biliary tract with the poorest outcome. Incidence is higher in north India predominantly seen in females. Gall bladder carcinoma (GBC) may present as abdominal pain, anorexia, weight loss, palpable lump, jaundice, gastric outlet or colonic obstruction, ascites. Early GBC has symptoms indistinguishable from gallstone disease. Incidental Gallbladder Carcinoma (IGBC) is the carcinoma of the gallbladder which is suspected for the first - time during cholecystectomy or which is Found on the histological examination of the gallbladder.***

Keywords: Gall stone, Laparoscopic Cholecystectomy, Gall bladder Cancer, Hepatic resection

1. Introduction

Laparoscopic Cholecystectomy (LC) is the accepted gold standard management for symptomatic gallstone disease. A LC which is performed for benign gall bladder disease rarely results in a diagnosis of unexpected gallbladder cancer. The incidence of gallbladder cancer which is diagnosed during or after a LC has been reported to be between 0.19% to 3.3%. We are reporting our experience with gallbladder cancer which was incidentally diagnosed after a LC which was performed for gallstone disease and cholecystitis.

2. Case Presentation

I am presenting a case of a 60 year old female belonging to low socioeconomic status who presented with right upper quadrant region pain since 2 months associated with vomiting

She had no underlying comorbidities or significant family history

Hematological investigations revealed Hb=12.8gm/dl, WBC=9900/cmm, S. bili=0.3 mg/dl (D - 0, IND - 0.3), ALP=88U/L
USG: gall bladder is distended and 14 mm sized calculus in fundus and GB wall thickness is 4mm

MANAGEMENT: Laparoscopic cholecystectomy was done. Operative findings: distended gall bladder with single gallstone, thick - walled GB, dense adhesion and difficult dissection of calot's triangle, suspicion of malignancy.

Pathology and stage: poorly differentiated cohesive carcinoma and pathological stage pT2.

3. Result

patient's CECT (A+P) was done after diagnosing incidental gallbladder carcinoma which was normal. As there is no evidence of metastasis, staging laparoscopy done which suggestive of no any disseminated metastasis which missed on imaging. So, Completion extended cholecystectomy done in form of wedge resection (2 cm) of GB bed of liver, lymphadenectomy of cystic, pericholedochal, hepatis artery, posterior superior pancreatico - duodenal, retroportal nodes and no need of extrahepatic bile duct resection as cystic duct stump margin frozen report came negative.

4. Discussion

The early - stage carcinoma is typically diagnosed incidentally because of the inflammatory symptoms which are related to the Coexistent cholelithiasis or cholecystitis. The association of GBC with cholelithiasis and chronic gallbladder inflammation is well known. The causes of the gallbladder mucosal inflammation Include infection, drugs (such as isoniazid and methyldopa), Genital anomalies (such as choledochal cysts and the anomalous junction of the pancreaticobiliary ducts) and primary sclerosing cholangitis. It has been presumed that a longstanding chronic inflammation which is caused by cholelithiasis plays a role in the tumour progression and that carcinogenesis and gallstones are seen in 54 - 97% of the patients of GBC. However, while most of the patients of GBC will have a history of cholelithiasis, only 0.3 - 3% of the patients with gallstones develop GBC. The other risk factors include a porcelain (calcified) gallbladder, a typhoid carrier state and gallbladder polyps. The ultrasonographic findings in early - stage GBCs are subtle, with considerable overlaps with the findings of acute and chronic cholecystitis. The features such as a thickened gallbladder wall, gallbladder or CBD stones, a gallbladder mass and a pericholecystic collection are not characteristic of GBC and they can be associated with cholecystitis. Unusual findings at surgery such as a gallbladder mass, dense adhesions of the organs which are adjacent to the gall bladder and a difficult dissection of the gallbladder from the liver bed are all pointers to the presence of a possible malignancy. Adenocarcinomas account for 90% of all the carcinomas of the gallbladder. The pathologic staging was recognized as an important prognostic factor. On the other hand, a re - exploration with a liver resection and a porta - hepatis lymph node dissection is a radical procedure which is carried out after further imaging, to rule out disseminated disease, which has proven to be beneficial

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in T2 and T3 gallbladder carcinomas which were first noted after laparoscopic cholecystectomies.

5. Conclusion

The importance of a histological examination of the post - cholecystectomy specimens cannot be underestimated. The nonspecific clinical features and the sonographic findings of the early GBCs make the pre - operative diagnosis difficult and an IGBC has been recorded in every reported series of the LC cases. A meticulous microscopic examination of the specimen, with special attention to the depth of invasion, range of the mucosal spread and the lymph vascular involvement, is critical, as it determines the subsequent management of the case.

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