

An Unusually Long Survival in Locally Advanced Carcinoma Gallbladder: First Case Report

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Abstract

Case Report

Survival in carcinoma gallbladder (Ca GB) is poor and an overall 5-year survival is below 5%, despite best available surgical and chemotherapeutic measures. Adjuvant and palliative treatment options have limited role, given the aggressive nature of this cancer, with sub-optimal response to chemotherapy. We are hereby to report a rare case of locally advanced carcinoma gall bladder, who received eight cycles of palliative chemotherapy, survived for twenty-two long years, and presented thereafter with tumour reactivation. He was managed by radical cholecystectomy with en-bloc resection of involved small bowel loop along with regional lymph node removal. Patient recovered well after the surgery, was discharged on sixth post-operative day. Histopathological review suggested moderately-differentiated adenocarcinoma gall bladder.

Keywords: Carcinoma gall bladder, long survival, palliative chemotherapy, laparoscopic radical cholecystectomy.

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INTRODUCTION

Gallbladder cancer being the most common and the most aggressive malignant tumour of the biliary tract with an overall 5-year survival less than 5% [1, 2]. The complete cure is only by the surgical resection, but at presentation, only 10% of patients are candidates for surgery with a curative intent [2]. Management of locally advanced and unresectable tumors include fluoropyrimidine chemoradiation or gemcitabine or fluoropyrimidine-based chemotherapy but no significant survival advantage has been seen [3,4]. Hereby we present a case of locally advanced Ca GB, treated with palliative chemotherapy, which had a prolonged indolent course of two decades, before undergoing curative resection.

CASE REPORT

A 61-year-old gentleman presented to us with pain right upper abdomen for 15 days. His appetite and weight were maintained. On examination, vitals were stable and general physical examination was unremarkable. On per abdominal examination there was a right subcostal scar. The abdomen was soft but there was vague lump palpable in the right hypochondrium. Bowel sounds were normal as the rest of systemic examination. His records revealed history of attempted open cholecystectomy 22 years back, where the

procedure was deferred in view of suspicious locally advanced GB mass, which later was confirmed with biopsy as well-differentiated adenocarcinoma of gall bladder. Patient received 8 cycles of fluoropyrimidine based palliative chemotherapy. Patient lost follow-up with the concerned hospital. On the basis of assessment and records, a working diagnosis of gall bladder mass was made and patient was admitted for evaluation. His blood investigations, hemogram, liver function tests, renal functions tests, viral markers were all normal. CA 19-9 level was 49.77 U/ml (Normal <37U/ml). CT scan abdomen showed heterogeneous mass in the fundus of Gall Bladder infiltrating adjacent small bowel, one enlarged LN around cystic duct and left renal calculus (figure 1 and 2). With a suspicion of locally advanced carcinoma gall bladder; a staging laparoscopy was planned. After proper preoperative preparation & informed consent, he underwent the procedure. Pneumoperitoneum was created by using Veress needle at left subcostal region, 5 mm left subcostal camera port was placed in view of previous surgical scar and other ports were made (epigastrium, right hypochondrium, left lumbar and supra umbilical region) under vision. A 30-degree, 10 mm laparoscope at supraumbilical port helped to achieve optimum vision throughout the procedure. After initial assessment, a meticulous adhesiolysis, exposed the GB area and uncovered the mass lesion along with portion of attached small bowel

(figure 3 and 4). Following no touch technique, liver was retracted; Calot's triangle was dissected out. Lymphadenectomy along the hepatoduodenal ligament was done. Cystic artery and cystic duct were skeletonised. Cystic artery and cystic duct were doubly clipped and divided. Gall bladder removed with wedge resection of the liver involving a 2 cm margin along with adherent small bowel loop (figure 5 and 6). Bowel continuity restored by anastomosis using endo GI staplers and 3-0 PDS. At previous scar site, incision was made. Specimen extracted through incision site. Incision closed using loop ethilon. Skin closed with skin staplers. One 24F drain placed in right para colic gutter. Patient was extubated and observed in ICU for one day. Clear liquids were allowed orally on postoperative day two and progressed slowly to soft diet as tolerated. Drain was removed on postoperative day three. He was discharged on postoperative day six. Histopathology report revealed P (T3 N0 Pn1 LV0) moderately differentiated adenocarcinoma of gall bladder fundus, infiltrating adjacent ileal wall, liver, cystic duct, and margins were negative. Patient was followed up in outpatient department at 1 month and 3 months and was doing well.



Fig-1: CT scan of abdomen showing gall bladder mass with bowel involvement (arrow)



Fig-2: CT scan of abdomen showing thickened gall bladder wall (arrow)



Fig-3: Laparoscopic view of adhesions around gall bladder



Fig-4: Small bowel (A) adherent with gall bladder (B)



Fig-5: Showing adherent bowel being divided using staplers



Fig-6: Showing liver parenchymal dissection around gall bladder

DISCUSSION

Gallbladder cancer is common and aggressive malignant tumour of the biliary tract with overall 5-year survival less than 5% [1, 2]. The poor prognosis is due to aggressive biologic behaviour and a lack of sensitive screening tests for early detection that results in delayed diagnosis and advanced stage of the disease at presentation [5]. The only chance for a complete cure is by surgical resection, but becomes feasible in hardly 10% of patients [2]. Demographics from India.

Northern India is having the highest incidence of gallbladder cancer in the World and the incidence of same has a specific geographic and ethnic variation, highest incidence rates in the world are 21.5/100 000 in females in Delhi [6]. Six Cancer registries of the Indian Council of Medical Research (1990–96) shows about 10 times lower incidence per 100 000 in South India in comparison with the North, the age-adjusted incidence rate for females being 0.8 and 8.9 in respectively[7].

Investigations for diagnosis of suspected gall bladder cancer are ultrasonography of abdomen, CECT abdomen; MRI/ MRCP can be done, in selective patients. In our case, as patient was diagnosed with carcinoma gall bladder previously we proceeded with CECT abdomen. Complete tumour resection being the only curative treatment for carcinoma gall bladder. The surgical intervention may range from simple cholecystectomy to being combined with partial hepatectomy, with or without regional lymph node dissection. Management of locally advanced and unresectable tumors include fluoropyrimidine chemoradiation or gemcitabine or fluoropyrimidine-based chemotherapy but no significant survival advantage has been seen [3, 4].

Survival in Ca GB depends mainly on early diagnosis and treatment and on the involvement of the layers of gall bladder wall. In Tis (in situ) and T1 (confined to the lamina propria or muscularis) the 5-year survival rates are over 95% [8]. Prognosis deteriorates as tumour invades the deeper layers of the gallbladder and it ranges from 70% with involvement of the sub-serosa (T2- invasion of perimuscular connective tissue) to 0% with the spread to adjacent organs (T3-penetration of the serosa)[9]. Our patient was diagnosed with well differentiated adenocarcinoma long back and has received 8 cycles of probably palliative chemotherapy. Patient presented to us after two decades, with two weeks of symptoms and underwent

surgery. As per authors this unusually long survival in diagnosed case of Ca GB, after completion of palliative chemotherapy is unknown and probably not reported earlier in the literature. Certainly, tumour biology has a role to play, as far as the response to chemotherapy and survival is concerned.

CONCLUSION

Carcinoma gall bladder is a dreaded disease, usually presents late and has high mortality and morbidity. There is every chance that patients with such disease may live longer than usual that may be contributed either to effects of chemotherapeutic drugs or nature of tumor biology and needs to be further assessed with further studies.

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