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Medicine

GALLBLADDER CANCER DIFFICULT DIAGNOSIS AND PATHOLOGICAL ASSOCIATION

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ABSTRACT:
GALLBLADDER NEOPLASM HAS THE BIGEST FREQUENCY OF EXTRAHEPATIC BILE DUCT TUMOURS, 80% OF THEM DEVELOPS ON LITHIC VESICLES.
WE PRESENT A CLINICAL CASE OF A 72-YEAR-OLD PATIENT, WHO WAS REFERRED TO HOSPITAL DUE TO ABDOMINAL AND RIGHT HYPOCHONDRIUM PAIN, LOSS OF APPETITE, FEVER, CHILLS, JAUNDICE AND WEIGHT LOSS, WITH NORMAL LABORATORY RESULTS. EXPLORATORY MEDIAN LAPAROTOMY WAS PERFORMED, WHO REVEALED A LARGE, WELL-DELIMITED, HARD TUMOUR, OF 10/8/6 CM THAT WAS REMOVED ALONG WITH ALL GREAT OMENTUM.
THE ADVANCED STAGE OF THE GALLBLADDER CANCER AND THE PRESENTS OF TWO OTHER TYPES OF CARCINOMA AT ONE ELDERLY PERSON HAVE LED TO AN INCOMPLETE CHOLECYSTECTOMY DRAINED ON KEHR TUBE.
THE LATE SIMPTOMATOLOGY CAUSED BY THE ADVANCED STAGE OF THE GALLBLADDER CANCER LED TO THE DISCOVERY OF THE OTHER TWO TUMORS (APPENDICULAR MUCOCELE, EPIPLOIC HEMANGIOSARCOMA), ASYMPTOMATIC AT THE TIME OF DIAGNOSIS.

KEYWORDS: GALLBLADDER CANCER, ADENOPATHY, APPENDICULAR MUCOCELE

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SHORT INTRODUCTION

Gallbladder neoplasm has the bigest frequency of extrahepatic bile duct tumours, 80% of them develops on lithic vesicles (gallstone cancer). In its early stages the clinical diagnosis is almost impossible, the suffering being dominated by lithiasis,

Gallbladder cancer is caught in the late study, the mortality being 5% of all deaths from malignant pathology tumour.

OBJECTIVES

The case presented show up the neoplastic backgraund of the patient to witch were associated simultaneously three different types of cancer:

- Gallbladder cancer
- Great omentum cancer
- Appendicular mucocele

MATERIAL AND METHOD

We present a clinical case of a 72-year-old patient, who was referred to hospital due to abdominal and right hypochondrium pain, loss of appetite, fever, chills, jaundice and weight loss (15 kg in the last six weeks) that lasted for the past four days. The physical examination reveal an spread abdomen by volume through well-represented fat panicle, mobile with respiratory movements, discreetly, spontaneously and on palpation painful in the right hypocondrium, without signs of muscular defense or detachable tumours. The liver is located at 2 cm below the costal margin, non-palpable spleen. Laboratory results were modified: urea – 106.16 mg/dl, creatinine – 1.43 mg/dl, GOT – 73.2 U/L, Gly – 149,83 mg/dl, Hb – 11.9 g/dl, L – 9430/mmc, PLT – 251000/mmc, but normal value of total bilirubin – 0,74 mg/dl and direct bilirubin – 0,29mg/dl.

The ultrasound showed up moderately hepatomegaly, without PLIH, relaxed, hypotonic gallbladder, with no edema, but with several stones of 7mm and biliary sludge, which seems to cover a possible proliferative process located in the fundic area; common bile duct – free(4 mm), intrahepatic bile ducts-normal, head of pancreas- 35 mm, possible pancreatic reaction. The other organs of normal appearance.

Pulmonary X-ray didn't show any modification, but on the eso-gastro-duodenal barite transit we discovered normal esophagus, stomach at 4 cm under the spina iliaca anterior-inferior, hypotonic, duodenum without modifications, in forced anteflexia hiatal hernia with a diameter of 4-5 cm.

Upper digestive endoscopy showed esophagus with normal mucosa, stomach with hyperemia, edema, superficial mucosal erosion of the body and pyloric antrum, fluid of biliary secretion in medium quantity; asimetric, spastic, permeable piloris; duodenal bulb with normal mucosa with biliary secretion liquid.

During colonoscopy the lumen is examinated up tp 60 cm of external anal sphincter; until this level- spastic, cudate, hyperhaustrate colon with solid mucosa; barium and faeces residues in the lumen.

After partial rebalancing of the patient, we underwent surgery who consisted in a exploratory median laparotomy, who revealed a large, well-delimited, hard tumour, of 10/8/6 cm that was removed along with all great omentum, and the piece were sent for extemporaneous histopathological examination (epiploic hemangiosarcoma).

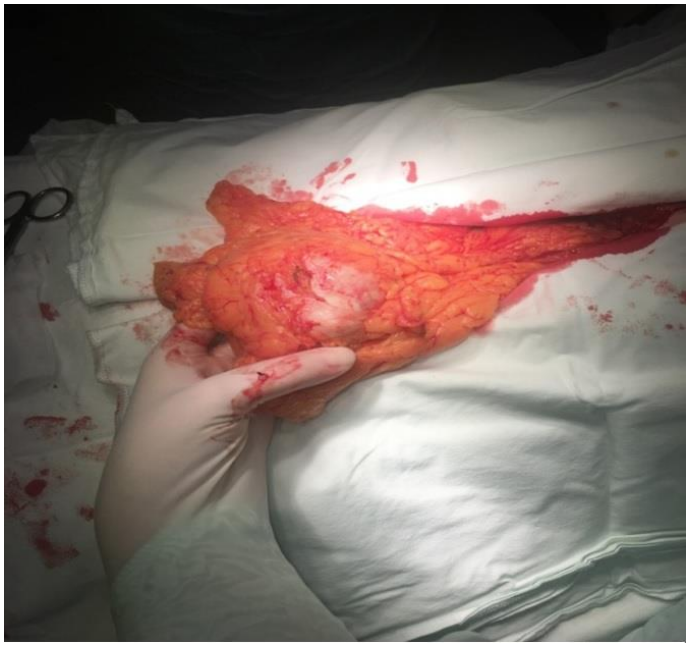

Figure 1.Greatomentumtumour

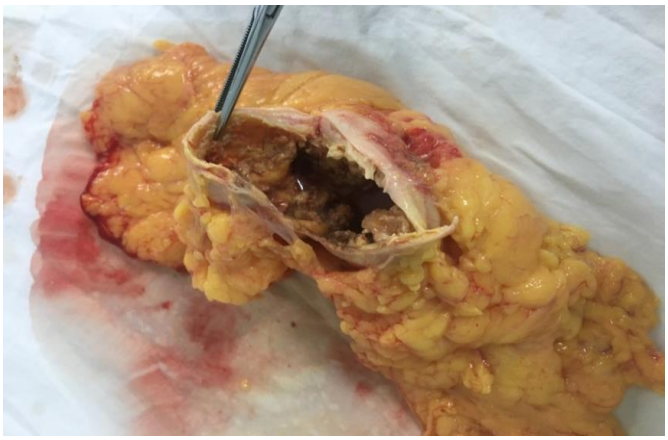

Figure 2. Section of the large epiploon tumour- macerated aspect

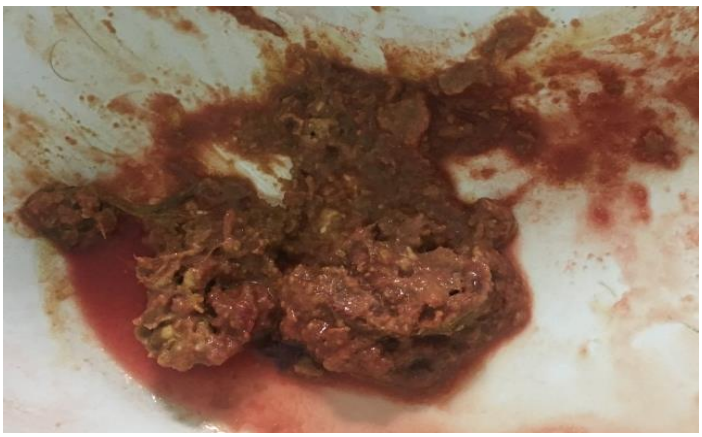

Figure 3.Macerated aspect of the large epiploon tumour

Exploration of abdominal cavity reveals a swollen appendage of 12/4 cm, in tension, with shiny serous.

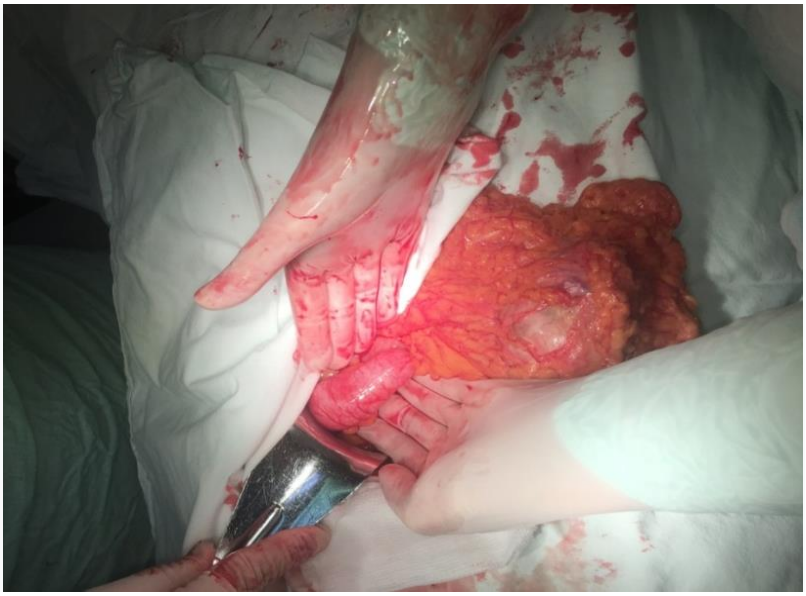

Figure 4.Appendicular mucocele

Intraoperative exploration revealed a large gallbladder, of 13/5/4/cm, in tension, with thickenedwalls, slightly congested serous; multiple hepatic, perigastric, periduodenopancreatic, pericystic adenopathy from which we collected 2 lymph nodes who belong to the pyloric and pericyst groups. Extemporaneous histopathological examination of those lymph nodes have showed up a moderately differentiated papillary adenocarcinoma.

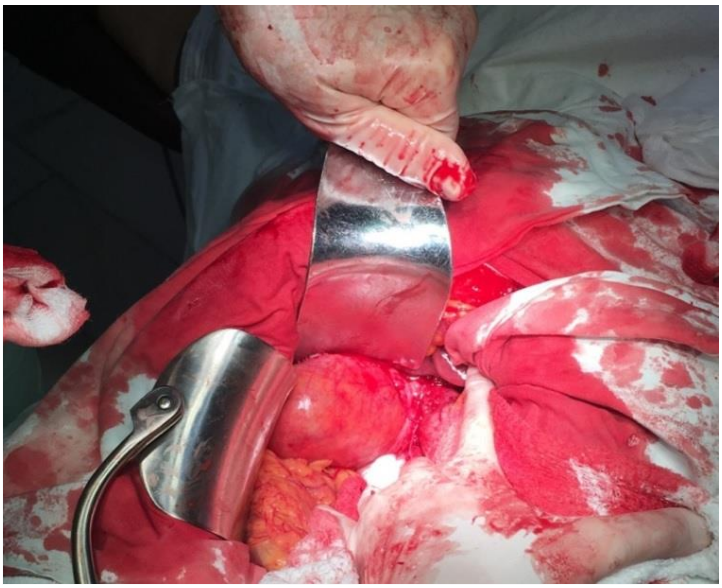

Figure 5. Intraoperative aspect of gallbladder

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The gallbladder was punctured deeply and about 50 ml of stasis liquid was evacuated. Through the bladder breach a few fragments of mucosa were taken and send for extemporaneous histopathological examination. The result was - well differentiated papillary adenocarcinoma. The coomun bile duct and implantation of the cystic canal in it couldn't be explored because of the adenopatic block present at this level. We tried the anterograde colecistectomy, but we couldn't due to the fact that the tumour invaded the liver parenchyma. The advanced stage of the gallbladder cancer and the presents of two other types of carcinoma at one elderly person have led to an incomplete cholecystectomy drained on Kehr tube.

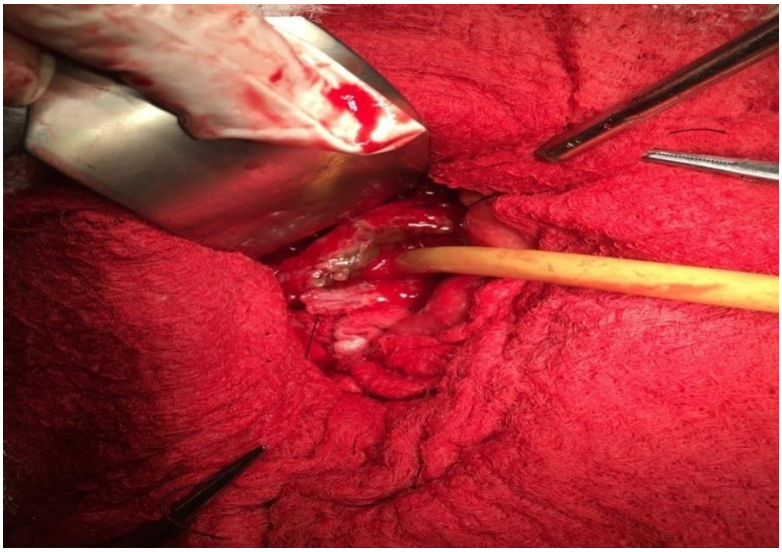

Figure 6.Drainage of gallbladder with Kehr tube

CONCLUSIONS

The particularity of the case consisted in association of three form of cancer, independent one from the other, discovered during the same surgery:

I. *Poorly differentiated adenocarcinomas of the gallbladder*
II. *Appendicular mucocele*
III. *Epiploic hemangiosarcoma*

The late simptomatology caused by the advanced stage of the gallbladder cancer led to the discovery of the other two tumors, asymptomatic at the time of diagnosis. The possibilities of a cytoreductive surgery in this case have decreased significantly with this pathological association.

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All authors had the same contribution.

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