

Editorial

Carcinoma in deeply located abdominal organs often presents in advanced stage as an indirect death notice.

With increasing life expectancy in Bangladesh malignant disease of different organs are also raising in magnitude which will be a major burden to health care providers in near future. Carcinoma pancreas, gallbladder, kidneys, adrenals, liver & colon often remain asymptomatic until they become advanced. Fulminating presentation in advanced stage of the disease put the physician, patient and near relatives in a dilemma as regards cost benefit of treating such diseases. There are instances that people sell their properties to mitigate the treatment cost at home and abroad. Frequently it happens that dependents has to bear the loss of early demise of their only earning member and their last belongings.

Mrs. Alta begum, 35 years admitted in female surgery ward with acute pain at right hypo chondriac region, ultra-sonography report showed gallstone with gall bladder mass with probable hepatic metastasis. CT guided FNAC confirmed the diagnosis of metastatic adeno-carcinoma.

Mrs. Shazu Begum, aged 55 years admitted in surgery unit with cholelithiasis with a suspicious soft tissue mass in gall bladder, laparotomy revealed a small soft tissue mass in gall bladder having porta-hepatis metastasis histopathology report of which was carcinoma gall bladder.

Akhtery Begum aged 43 years had a cholecystectomy four month back, omental biopsy showed a metastasis, she was on chemotherapy for last three and a half months. Now she developed severe fixed abdominal pain with vomiting probably due to retroperitoneal involvement of shelf of malignant tissues and also involvement of gut.

Mr. Ajmat Ullah aged 56 years had laparoscopic

cholecystectomy for gall stone disease, gall bladder histopathology reported as carcinoma involving muscle layer. Mr. Ullah is moving from surgeon to surgeon, and oncologist to oncologist for opinion regarding further surgery, and or chemotherapy. All the above scenarios are presentation of GB cancer.

Although gall bladder carcinoma is a relatively uncommon malignant tumor. It is the 5th most common tumor of gastrointestinal tract and accounts for 3% of all the gastrointestinal tumors. Chronic inflammation, gallstone disease, porcelain gall bladder, gall bladder polyp, chronic salmonella infection, congenital biliary cysts, and abnormal pancreaticobiliary duct junction are well-known predisposing factors of GB cancers. It may be associated with gallstones in 70% of cases and the risk of malignant metaplasia correlates with the length of time gallstones have been present. The tumor is twice as common in women as in men, as one would expect from the association with gallstones.

Patient may be asymptomatic at the time of diagnosis. The most common presenting complaint is of right upper quadrant pain or cholecystitis. Other cases present with anorexia, nausea, weight loss and obstructive jaundice with or without cholangitis due to secondary involvement of the common bile duct. Patient may present with advanced malignant disease like palpable gall bladder mass, hard nodular liver, ascites & gastric outlet obstruction etc.

The preoperative diagnosis is made with ultrasonography and confirmed by a CT scan or MRCP. Contemplated ERCP is a better option for evaluation and insertion of a biliary stent. Staging laparoscopy usually performed to detect the peritoneal or liver metastasis just prior to laparotomy which can help in avoiding unnecessary laparotomy in

about 33% cases. Despite the advances of medical imaging, most of the gallbladder carcinoma is incidentally detected intra-operatively or on histopathological examination after cholecystectomy.

Choice of treatment primarily depends on tumor stage. If a localized carcinoma is recognized at laparotomy, cholecystectomy should be performed along with en block wedge resection of an adjacent 2 cm of normal liver tissue and dissection of the regional lymphnodes. Patients can have the disease diagnosed following histopathological examination of the gall bladder removed for presumed benign disease. In these cases the need for further surgery is determined by the stage of disease. For early stage, disease confined to the mucosa or muscle of the gallbladder no further treatment is indicated. However, for transmural disease, a radical en-bloc resection of the gallbladder fossa and surrounding liver tissue along with the regional lymph nodes should be performed. If the initial procedure is performed laparoscopically, the laparoscopic port sites should be excised. Port site metastasis is a marker for a greater likely hood of subsequent peritoneal disease. A second look should always be offered in selected cases as 5-year survival improves by completion of radical cholecystectomy. For majority of patients, a non-operative

approach to palliation is the best in the form of biliary stenting by endoscopic or transhepatic means, gastro jejunostomy or palliative cholecystectomy. In situations where curative resection is not possible, radiotherapy with or without chemotherapy has been tried but with only little impact on survival. Poor general condition and presence of jaundice may also suggest inoperable disease. However, with improved surgical technique and postoperative management, in case of stage II and stage III disease mortality has reduced to 5 percent and at the same time an improved survival of 35 to 42% has been achieved with radical resection.

The message from the above discussion, in gall bladder malignancy the only hope of cure is early detection, early adequate surgery, and if anyone having the above mentioned predisposing factors get those treated early as once the disease is advanced the cure rate is negligible. Main stay of treatment is surgery and role of chemotherapy and radiotherapy is not yet satisfactory.

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