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Original Article

Incidental Diagnosis of Unplanned Gallbladder Carcinoma During or Following Laparoscopic Cholecystectomy

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ABSTRACT

Introduction: *The most prevalent biliary tract cancer and the fifth most common type of gastrointestinal cancer is gallbladder carcinoma (GBC). Most individuals receive a diagnosis of GBC accidentally following a cholecystectomy for a presumably benign condition. Overt GBC that is clinically present is frequently far-progressed and unresectable. Those discovered by chance following open or laparoscopic cholecystectomy typically have early-stage tumors. It is an extremely fatal tumor. The incidental diagnosis of gallbladder cancer is more common due to the rise in cholecystectomies since laparoscopic cholecystectomy (LC) gained widespread acceptability. Analyzing incidental gallbladder cancer found during or following laparoscopic cholecystectomy was the goal of this investigation.* ***Methods & Material:*** *This prospective study was conducted at the Department of Surgery, Naogaon Medical College, Naogaon, Bangladesh, from July 2018 to June 2020. A total of 250 patients were selected for this study purpose as per inclusion criteria. Statistical analysis of the results was obtained by using Statistical Packages for Social Sciences (SPSS-17) software.* ***Results:*** *In this study, most of the patients (100, 40.0%) belonged to the >60 years age group, followed by (80, 32.0%) of 60 years age group. Among the study respondents, most of the patients (10,50.0%) were found to have poorly differentiated adenocarcinoma, followed by (05, 25.0%) moderately Differentiated adenocarcinoma, (02, 10.0%) well-differentiated adenocarcinoma, primary malignant*

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(03, 10.0%), and 01 (5.0%) patient were found to have metastatic cholangiocarcinoma. Regarding clinical presentation, most of the respondents (10, 50.0%) presented with pain in the right upper quadrant, followed by (05, 25.0%) moderate jaundice, pain with jaundice (03, 15.0%), and (2, 10.0%) pain with a palpable mass. Concerning clinical and histopathological diagnoses, 5 (25.0%) patients were primarily diagnosed as chronic cholecystitis with CBD stone but later they were found to have PDA in histology, another 5 (25.0%) patients were primarily diagnosed as obstructive jaundice with mirizzi syndrome but later they found to have PDA, ca of the head of the pancreas was diagnosed primarily in 5 (25.0%) patients who revealed MDA after histopathological analysis. ***Conclusion*** *Incidental diagnosis of gallbladder carcinoma was very high in this study (8.0%). Concerning clinical and histopathological diagnoses, 25.0% of patients were primarily diagnosed as chronic cholecystitis with CBD stone but later found to have PDA in histology, another 25.0% of patients were primarily diagnosed as obstructive jaundice with mirizzi syndrome but later they found to have PDA, ca of the head of the pancreas was diagnosed primarily 25.0% patients who revealed MDA after histopathological analysis.*

Keywords: *Gall Bladder, Carcinoma, Histology, Cholecystectomy*

INTRODUCTION

The most prevalent biliary tract cancer and the fifth most common type of gastrointestinal cancer is gallbladder carcinoma (GBC). The diagnosis of GBC in most patients is made incidentally after the cholecystectomy for presumed benign disease. Clinically overt GBC is often far advanced and beyond the scope of resection. Those detected incidentally after open or laparoscopic cholecystectomy tends to be in the early tumor stages.[1] Gallbladder cancer is characterized by rapid progression and a poor prognosis with a high mortality rate and is a complex disease to treat. The term "incidental gallbladder carcinoma" refers to gallbladder cancer that was unintentionally discovered during a histological analysis of the gallbladder or that was initially believed to exist after a cholecystectomy. The number of cases of GBC during and after LC has increased as laparoscopic cholecystectomy has become more widely used and as preoperative GBC diagnosis has become more challenging.[2] Gallbladder carcinoma (GC) is a highly lethal neoplasm. The incidental diagnosis of gallbladder cancer is more common due to the rise in cholecystectomies since laparoscopic cholecystectomy (LC) gained widespread acceptability.[3] Re-resection is frequently advised when gallbladder cancer is unintentionally found after cholecystectomy. However, the incidence of finding the additional disease at the time of re-resection remains poorly defined. Aggressive re-resection for incidental gallbladder carcinoma is warranted as the majority of patients have residual disease. Even if common duct resection does not result in a higher lymph node count, it should be done for patients with positive cystic duct margins at the time of resection because over one-third of them will still have common bile duct illness.[4] Gallbladder carcinoma has a terrible prognosis, with a less than 5% overall 5-year survival rate. Stage-adjusted therapy can result in a 5-year survival rate of up to 75% in cases of early illness. Gallbladder cancer incidence varies greatly by region, which can only be explained by the combination of hereditary variables and

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their modification.[5] Laparoscopic Cholecystectomy (LC) is the accepted gold standard management for symptomatic gallstone disease for the past 2 decades. With the advantages of a shorter hospital stay, decreased post-operative pain, and an early resumption of normal activities, this procedure has now become routine in the treatment of benign gallbladder disease in general surgical units all over the world. Rarely can an LC for benign gallbladder illness lead to a surprise gallbladder cancer diagnosis.[6] Only the earliest stages: T1a, may benefit from a straightforward cholecystectomy as a treatment. In situations of T2 tumors and more advanced stages of the disease, reoperation is advised. On the other hand, debates continue to surround the necessity of a more drastic resection for T1b GBC. The optimal degree of hepatic resection during reoperation as well as its ability to prevent a liver recurrence are similarly unknown.[7] In literature gallbladder cancer incidence is 0,3-1,5%intra and postoperatively respectively; it also seems to be increased over the last years.[8] Only 30% of gallbladder carcinomas are suspected before surgery, and the other 70% are typically found by chance during or after surgery during a pathological investigation.[9] Analyzing incidental gallbladder cancer found during or following laparoscopic cholecystectomy was the goal of this investigation.

OBJECTIVE

General Objective

- To investigate incidental gallbladder cancer found during or following laparoscopic cholecystectomy.

Specific Objectives

- To see the clinical presentation of patients with gallbladder disease.
- To see the histological pattern of different GB carcinoma.

METHODS & MATERIAL

This prospective study was conducted at the Department of Surgery, Naogaon Medical College, Naogaon, Bangladesh from July 2018 to June 2020. A total of 250 patients were selected for laparoscopic cholecystectomy among which 20 patients were found to have incidental gallbladder carcinoma. All subjects underwent proper surgical procedures after obtaining informed written consent. A pre-designed data collection sheet was used to collect data containing the history & physical examination findings of the patient and the intraoperative and postoperative findings. Statistical analysis of the results was obtained by using Statistical Packages for Social Sciences (SPSS-17) software and the level of significance was measured by using an appropriate procedure like the chi-square test (X^2). All data were kept confidential and used only for this study purpose. Ethical clearance was obtained from the ethics committee of Naogaon Medical College.

Inclusion Criteria

- Patients over 30 years of age.
- Patients who indicated cholecystectomy
- Patients who had given consent to participate in the study.

Exclusion Criteria

- Patients ≤30 years of age

- Patients who did not give consent to participate in the study.

RESULTS

Table 1: Distribution of subjects according to age. (N=250)

Age (years)	N	%
31-40	10	4.0
41-50	60	24.0
51-60	80	32.0
>60	100	40.0

In this study, most of the patients (100, 40.0%) belonged to the >60 years age group, followed by (80, 32.0%) 51-60 years age group. [Table 1]

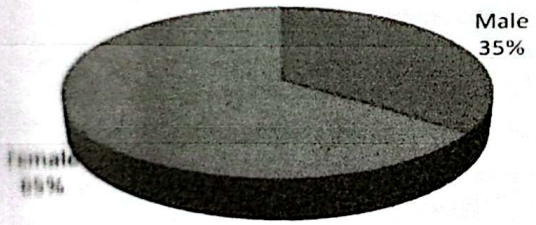


Figure 1: Sex distribution of study population (N=250)

Female preponderance was seen in this study (65.0%)[Figure 1]

Table 2: Histological types of gall bladder tumors (n=20)

The histological type of gallbladder tumor	n	%
Primary malignant	02	10.0
Well-differentiated adenocarcinoma	02	10.0
Moderately differentiated adenocarcinoma	05	25.0
Poorly differentiated adenocarcinoma	10	50.0
Metastatic cholangiocarcinoma	01	5.0

Among the study respondents, most of the patients (10,50.0%) were found to have poorly differentiated adenocarcinoma, followed by (05, 25.0%) moderately differentiated adenocarcinoma, (02, 10.0%) well-differentiated adenocarcinoma, primary malignant (02, 10.0%), and 01 (5.0%) patient were found to have metastatic cholangiocarcinoma. [Table 2]

Table 3: Common clinical presentation of gallbladder carcinoma (n=20)

Clinical presentation	n	%
Pain in the right upper quadrant	10	50.0
Moderate jaundice	05	25.0
Pain with a palpable mass	02	10.0
Pain with jaundice	03	15.0

Regarding clinical presentation, most of the respondents (10, 50.0%) presented with pain in the right upper quadrant,

followed by (05, 25.0%) moderate jaundice, pain with jaundice (03, 15.0%), and (2, 10.0%) pain with a palpable m [Table 3]

Table 4: Clinical and histopathological diagnoses of incidental GBC (n=20)

Clinical diagnosis	Gross feature	Histological diagnosis	n (%)
Acute cholecystitis	Fungating mass	WDA & metastatic cholangiocarcinoma	03 (15.0%)
Obstructive jaundice with mirizzi syndrome	Thickened wall	PDA	05 (25.0%)
Chronic cholecystitis with CBD stone	Thick fibrosed wall	PDA	05 (25.0%)
Cahead of the pancreas	Granular mucosa	MDA	05 (25.0%)
GB polyp	Solid mass	Primary malignant carcinoma	02 (10.0%)

WDA= well differentiated adenocarcinoma, PDA= poorly differentiated adenocarcinoma, MDA= moderately differentiated adenocarcinoma

Concerning clinical and histopathological diagnoses, 5 (25.0%) patients were primarily diagnosed as chronic cholecystitis with CBD stone but later they were found to have PDA in histology, another 5 (25.0%) patients were primarily diagnosed as obstructive jaundice with mirizzi syndrome but later they found to have PDA, ca of the head of the pancreas was diagnosed primarily in 5 (25.0%) patients who revealed MDA after histopathological analysis. [Table 4]

DISCUSSION

In this study, most of the patients (100, 40.0%) belonged to the >60 years age group, followed by (80, 32.0%) 51-60 years age group. Female preponderance was seen in this study (65.0%). There w 4 men and 16 women; the median ag this group was 65.7 years (range 81 years) in another study that relatable to this study.[10] Among the st respondents, most of the pati (10,50.0%) were found to have po differentiated adenocarcinoma, follo by (05, 25.0%) moderately differenti adenocarcinoma, (02, 10.0%) w differentiated adenocarcinoma, pri malignant (02, 10.0%), and 01 (5 patient were found to have metast cholangiocarcinoma. Adenocarcino were the most prevalent histological t with poor differentiation and were usu detected at stage IIA, according to a st 1.4 percent of gallbladder cases w incidental primary carcinomas, which w frequently found at stage I. Only percent of gallbladder cancers histological proof were successf detected preoperatively and du surgery. Three cases of thickened GB

of inflated GB, and one case of a GB were among the incidental tumors that were discovered intraoperatively; three other cases had no gross abnormality noted.[11] In another study of 33 patients studied, 9 were men and 24 were women. 26 patients underwent laparoscopic cholecystectomy alone, and 7 underwent extra drastic surgery. There were 2 Tis, 6 T1a, 4 T1b, 11 T2, and 4 T3 tumors, according to the TNM stage. Male patients had a considerably greater incidence of T2 and T3 tumors (P = 0.02), additional second resections (P = 0.046), recurrence (P = 0.016), and moderately and poorly differentiated cancers (P 0.001).[12] Concerning clinical and histopathological diagnoses, 5 (25.0%) patients were primarily diagnosed as chronic cholecystitis with CBD stone but later they were found to have PDA in histology, another 5 (25.0%) patients were primarily diagnosed as obstructive jaundice with mirizzi syndrome but later they found to have PDA, ca of the head of the pancreas was diagnosed primarily in 5 (25.0%) patients who revealed MDA after histopathological analysis. According to the study, surgery was performed on 35 patients (46%) and endoscopic treatment on 72 patients (19%), but no intervention was made for the remaining patients due to the spread of the disease. Stage I GBC was present in 2.0%, stage II in 2.7%, stage III in 17.5%, stage IVa in 18.9%, and stage IVb in 29.8% of the patients who had surgery.[13] In a different study, a total of 2034 cholecystectomies were included. Ten patients (0.5%) with GBC were found, and each had a corresponding macroscopic finding, such as focal hardness (n=1), a thicker wall (n = 5), acute inflammation and necrosis (n = 1), or probable neoplasia (n = 3).[14] In another study, of 4,776 cholecystectomies identified, 12 (0.25%) were cases of IGBC. These cases had a higher median age (68 vs 54 years, $p<0.001$) and a higher proportion were emergency operations (50% vs 12%, $p<0.001$). All cases had some form of macroscopic abnormality, most commonly wall thickening ($n=6$, 50%).[15]

LIMITATIONS OF THE STUDY

The study was conducted in a single hospital with a small sample size. So, the results may not represent the whole community.

CONCLUSION

Incidental diagnosis of gallbladder carcinoma was very high in this study (8.0%). Concerning clinical and histopathological diagnoses, 25.0% of patients were primarily diagnosed as chronic cholecystitis with CBD stone but later found to have PDA in histology, another 25.0% of patients were primarily diagnosed as obstructive jaundice with mirizzi syndrome but later they found to have PDA, ca of the head of the pancreas was diagnosed primarily 25.0% patients who revealed MDA after histopathological analysis.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

RECOMMENDATION

Extended radical resection is advised for patients with T1b or more advanced IGBC, while simple LC is suitable for T1a patients with a clear margin and an intact gallbladder. To lower the likelihood of disease relapse and port-site recurrences, an undamaged surgical specimen and the use of plastic retrieval bags are crucial. For successful outcomes, early diagnosis, thorough perioperative assessment, and precision surgery are crucial. So, further studies should be conducted involving a large sample size and multiple centers in this regard and every cholecystectomy specimen should be examined histopathologically to detect possible incidental carcinomas.

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