

Unusual Presentation of Metastatic Gallbladder Carcinoma at a Young Age of 26 years-Letter to Editor

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Dear Editor,

Gallbladder malignancy is a rare yet highly aggressive disease which is unresectable in 80% of cases at presentation [1]. It usually presents after 65 years of age. It is categorized to be the 5th commonest malignancy of gastrointestinal tract, occurring in 2.5 people per 100,000 and is the commonest biliary cancer [1,2]. The youngest reported case of gallbladder carcinoma was in an 11-year-old Navajo girl. Gallbladder carcinoma is the second most common gastrointestinal malignancy in Southwest American Indians. Our patient was the youngest reported in the Asian population. Another unexpected feature of our patient was the absence of chronic inflammation that usually precludes gallbladder malignancy. Gallbladder cancer is 7 times more common in patients with cholelithiasis and chronic cholecystitis. Thus, we need to keep a high index of suspicion for the early diagnosis of such malignancy in young patients without a history of chronic cholecystitis.

A female patient, 26 years old, presented to the medical outpatient department with 4 months history of progressive upper abdominal pain which increased after eating. It radiated to back and right shoulder blade. She had anorexia and unintentional weight loss. There was no past history of cholecystitis or family history of malignancy. She was seen by general practitioners and was advised ant-acids and analgesics. It was only after significant ill health that she presented to us. On examination, she had scleral icterus and conjunctival pallor, emaciated appearance, mildly tender yet hard hepatomegaly. Liver border extended 6cm below right hypochondrium in mid clavicular line with irregular margins and surface. No ascites, splenomegaly, bone tenderness or other systemic involvement was appreciated clinically.

The patient had shown anemia, leukocytosis, raised ESR and cholestatic hepatic profile. She had normal Chest X-ray, renal function tests, and serum electrolytes. Her USG abdomen showed multiple hypodense lesions in the liver with thickened gallbladder wall and no evidence of

gallstones. HIDA scan was not performed in this patient. Contrast-enhanced CT scan of the chest, abdomen, pelvis revealed thickened gall bladder wall, significant infiltration in gallbladder fossa and adjacent hepatic parenchyma with numerous hypodense lesions in both lobes of the liver, thrombosed right branch of the portal vein and mild intrahepatic biliary dilatation. There was mild fat stranding in perihepatic region/paracolic space likely representing peritoneal carcinomatosis. No evidence of bone, pelvic, respiratory metastasis was found. She was subjected to core biopsy of the hepatic lesion for a definite diagnosis. Histopathology showed moderately differentiated adenocarcinoma with immunohistochemical staining positive for Cytokeratin 7 and 19 and negative for Cytokeratin 20. Thus, the diagnosis of gallbladder carcinoma with liver metastasis and peritoneal carcinomatosis was made (Stage IV, Grade 4).

Surgery is considered only curative treatment at the early stage, beyond which the tumor follows an incurable course. A rational approach for gallbladder carcinoma by Glenn and Hays in 1954 included wedge resection of the gallbladder bed and regional lymphadenectomy[4]. Definitive resection depends on the stage and location of the primary lesion as well as whether it is a repeat resection after a previous cholecystectomy. Simple cholecystectomy can be done for T1 (stage Ia) tumors. Any suspicious nodes should be removed for pathologic examination. Stage Ib, II, and selected stage III (T4, N0) tumors should be treated with resection of the gallbladder along with liver segments IVb and V, and lymph node dissection. Stage IV tumors should be palliated [4]. Another treatment option for palliation of advanced malignancy is chemotherapy. Gemcitabine-based combination (with cisplatin and oxaliplatin or with capecitabine) showed longer survival than with gemcitabine alone [5]. Our patient was a candidate for palliative treatment because of advanced stage (TNM Stage IV). The family opted for conservative management.

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This early presentation can be explained by genetic aberration characterized by microsatellite instability as found by Rashid and colleagues [6]. Moreover, traditional risk factors of old age, chronic inflammation, obesity might not be present in some cases. Single known risk factor in our patient was female gender [7]. The preponderance of this cancer in females is even greatest in patients less than 40 years old, with a female-to-male ratio of 20:1.

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