



Hepatobiliary Surgery

AN UNUSUAL PRESENTATION OF GALL BLADDER CANCER
CHOLECYSTOCUTANEOUS FISTULA

Dr Gajendra Bhati

Mch Surgical Gastroenterology, Assistant Professor, Department of Surgical Gastroenterology, Adesh institute of Medical science and research , Bathinda, India

Dr Arjun Sharma*

MS General Surgery, Senior Resident, Department of Surgery, Government Medical College, Amritsar, India*Corresponding Author

Dr Biju pottakatt

Mch surgical Gastroenterology, Professor, Department of Surgical Gastroenterology , JIPMER, Puducherry, India

ABSTRACT

Biliary fistula is anomalous tract from biliary system to organ,cavity or free surfaces. Internal.Biliary fistulas are much more common than external biliary. Cholecystocutaneous biliary fistulas are usually occur secondary to ignored gallstone disease, but it can occur secondary to retained stones after cholecystectomy,after partial cholecystectomy and percutaneous cholecystotomy or rarely after gallbladder carcinoma.

KEYWORDS : 1:Biliary fistulae 2:Gallbladder cancer

INTRODUCTION:

Cholecystocutaneous fistula was first documented by Thilesus in 1670 [1]. Spontaneous biliary fistulae are usually a complication of ignored chronic cholelithiasis causing perforation, which may become adherent to neighbouring structures or rarely communicates to the abdominal wall. The incidence of External Biliary fistulae has now become rare because of early timely management of biliary tract diseases due to wider availability of usg and ct scan [2]. Fewer than 20 case of spontaneous cholecysto-cutaneous fistula in last 50 years have been documented in the medical literature [3].

We now report a case of gall bladder carcinoma invading parietal wall and presenting as external biliary fistula

CASE PRESENTATION:

65 yr old male presented with upper abdominal pain, anorexia and weight loss for 1 month duration. He noticed yellowish discoloration of eyes and urine, for 15 days duration and intermittent non bilious vomiting and fever for same duration. He underwent gastrojejunostomy 20 years back for peptic ulcer disease and gastric outlet obstruction. He was admitted and evaluated outside with MRI abdomen which showed mass in the fundus of gall bladder with adjacent infiltration in segment IV b of liver, suspected sealed off gall bladder perforation and bilioma in parietal abdominal wall [Figure 1]. On investigations his liver function test showed obstructive jaundice and CA 19-9 was >1000 U/ml. He was referred to our department. On examination patient was thin built, poorly nourished and icteric. On abdominal examination he had hepatomegaly four cms below the costal margins, and a tender swelling size 3 x 3 cms in right hypochondrium in midaxillary line, skin over swelling was tender and red [Figure 2]. An incision was given over swelling and 10ml of biliopurulent fluid along with small multiple black pigmented stones were drained [Figure 3]. The cholecystocutaneous fistula continued draining stones for next few days. His contrast enhanced CT abdomen revealed multiple radioopaque gall stones in parietal abdominal wall adjacent to fundus of gall bladder and heterogeneously enhancing mass lesion in the fundus of gall bladder with infiltration into adjacent liver, dilated common hepatic and common bile duct and dilated intrahepatic biliary radicals. Multifocal metastases were found in the right lobe of liver along with multiple hepatoduodenal, peripancreatic and aortocaval lymph nodes [Figure 4]. Skin biopsy taken from fistula tract showed dermis infiltrated by malignant cells [Figure 5], as well as fine needle aspiration cytology from gall bladder showed adenocarcinoma. Patient had cholangitis and planned for percutaneous biliary drainage but his general condition worsened and he left against medical advice.

DISCUSSION:

Gall bladder cancer is associated with rapid spread leading to poor prognosis for the patient. Early mucosal spread of cancer often remain asymptomatic and remains difficult to detect, Hence about 60-70% patients present with locally advanced or metastatic disease and the

median survival of this disease is <6 months [4]. The mild symptoms during early phase are often neglected or confused with commoner benign conditions like cholelithiasis. Advanced gall bladder cancer can be associated with clinically palpable abdominal mass, obstructive jaundice, duodenal compression causing its obstruction and malignant ascites. Gall bladder cancer has tendency to metastasise early through the lymphatic channel and hematogenous route and by direct malignant cell breach into the liver as well. It also has propensity to seed and grow in the peritoneal cavity, as well as along the needle biopsy tract and laparoscopic port sites. Abdominal wall infiltration and cutaneous fistulization however, very rare and stage IV disease which is considered unresectable. Palliative management of advanced unresectable disease can be done by Chemotherapy and shown to give survival advantage for the patient [5]. Irreversible electroporation (IRE) is a new non-thermal ablative technique that damages the cell membranes leading to apoptosis of cells (6).The trial has given encouraging results for the treatment of pancreatic cancer, liver cancer, and prostate cancer (7). Just recently, there have been reports of a program of irreversible electroporation being initiated in PGI, Chandigarh for the late stage of GB carcinoma [8]

CONCLUSION:

Spontaneous cholecysto-cutaneous fistulization in a case of gall bladder cancer indicates advanced nature of disease and poor prognosis. This entity should be kept in mind for elderly patients presenting with mass in right upper quadrant and fistula discharging bile or stones with associated features of malignancy.

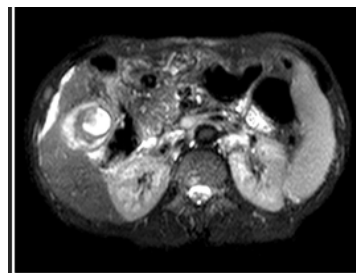
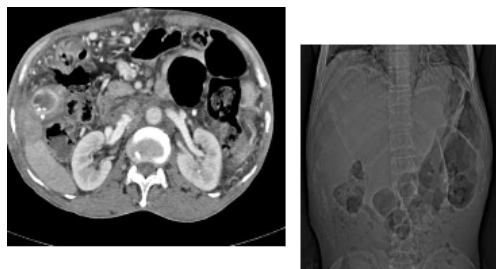
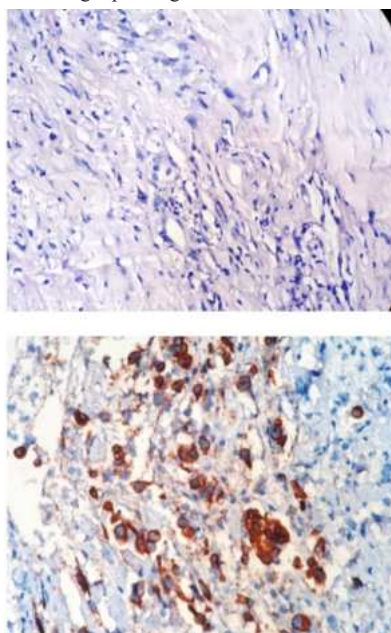


FIGURE 1 : MRI abdomen showing perforated gallbladder



FIGURE 2 parietal wall swelling with impending rupture**FIGURE 3** : multiple black pigmented stones draining**FIGURE 4** : tomogram showing multiple stones and axial contrast tomogram showing ruptured gall bladder**FIGURE 5** : Photomicrographs showing skin invaded by malignant cell**REFERENCES:**

- [1] Davies MG, Tadros E, Gaine S. Combined internal and external biliary fistulae treated by percutaneous cholecystolithotomy. *Br J Surg* 1989; 76:1258
- [2] Pezzilli R, Barakat B, Corinaldesi R, Cavazzab M. Spontaneous cholecystocutaneous fistula. *Case Rep Gastroenterol*. 2010;4:356–60.
- [3] Reed MWR, Tweedie JH. Spontaneous simultaneous internal and external biliary fistulae. *Br J Surg* 1985; 72:538
- [4] Kiran RP, Pokala N, Dudrick SJ. Incidence pattern and survival for gallbladder cancer over three decades--an analysis of 10,301 patients. *Ann Surg Oncol* 2007; 14:827-32.
- [5] Memon MA, Anwar S, Shiwani MH, Memon B (2005) Gall bladder carcinoma: a retrospective analysis of twenty two years experience of a single teaching hospital. *Int Semin Surg Oncol* 2 (1):6
- [6] Vogel, J. A. et al. Time-dependent impact of irreversible electroporation on pancreas, liver, blood vessels and nerves: a systematic review of experimental studies. *PLoS ONE* 11,e0166987. <https://doi.org/10.1371/journal.pone.0166987> (2016).
- [7] Scheffer, H. J. et al. Irreversible electroporation for non thermal tumor ablation in the clinical setting: a systematic review of safety and efficacy. *J. Vasc. Interv. Radiol.* 25, 997–1011.
- [8] Narula MK. Chandigarh: hope for gallbladder cancer patients not eligible for surgery [Internet] 20 p 23. [cited Mar 19]. Available from: <https://www.hindustantimes.com/cities/chandigarh-news/chandigarh-hope-for-gallbladder-cancer-patients-not-eligible-for-surgery-101679182426962.html>