Cholangiocarcinoma and its management

S A Khan, A Miras, M Pelling, S D Taylor-Robinson

This is an introduction to the Gut tutorial ''Cholangiocarcinoma and its management'' hosted on BMJ Learning—the best available learning website for medical professionals from the BMJ Group.

Cholangiocarcinoma originates in the biliary epithelium. Mortality rates from intrahepatic cholangiocarcinoma appear to have risen steadily over the past 30 years and it now causes more deaths than hepatocellular carcinoma annually in England and Wales. Primary sclerosing cholangitis is the commonest known predisposing factor for cholangiocarcinoma in the UK. The commonest presenting clinical features of perihilar or extrahepatic tumours are those of biliary obstruction. CA 19–9 is elevated in up to 85% of patients with cholangiocarcinoma and has a sensitivity of 75% and specificity of 80% in patients with primary sclerosing cholangitis, but its value in patients without primary sclerosing cholangitis is limited. Good quality magnetic resonance imaging (MRI) is the optimal imaging investigation for suspected cholangiocarcinoma, providing accurate information on biliary anatomy and local invasion, extent of duct involvement with magnetic resonance cholangiopancreatography (MRCP) and vascular involvement by magnetic resonance angiography. Up to 50% of patients are lymph node positive at presentation, which is associated with poor surgical outcome. Perhaps 10–20% of patients have peritoneal involvement and laparoscopy could be considered to determine the presence of peritoneal or superficial liver metastases in those considered resectable on imaging. Surgery is the only curative treatment for patients with cholangiocarcinoma with a 9–18% five year survival for proximal bile duct lesions and 20–30% for distal lesions. Routine preoperative biliary drainage is no longer recommended if there is no undue delay prior to surgery, but in certain patients who are severely malnourished, or who are suffering from acute suppurative cholangitis, preoperative drainage is beneficial.

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Chronic diarrhoea

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This is an introduction to the Gut tutorial ''Chronic diarrhoea'' hosted on BMJ Learning—the best available learning website for medical professionals from the BMJ Group.

Diarrhoea predominant irritable bowel syndrome is by far the most common cause of abdominal pain and diarrhoea in patients aged 20 to 40 years. Irritable bowel syndrome as a whole affects around 10% of the UK population. The female to male ratio is 1.5:1. Between 6 and 17% of patients with irritable bowel syndrome report that their symptoms began after an attack of acute bacterial gastroenteritis. Indeed, bacterial gastroenteritis in the previous year proved to be the strongest predictor of the development of irritable bowel syndrome. Around 3% of patients meeting the Rome criteria for irritable bowel syndrome have been shown to suffer from unrecognised coeliac disease. Although initially asymptomatic, many patients, when put on a gluten free diet, recognise that they have been tolerating low grade symptoms for many years. The yield from further investigations is small but occasionally of value. In patients with an established diagnosis of irritable bowel syndrome, 2% of stool samples were abnormal and around 2% of colonoscopies show occult or microscopic inflammatory bowel disease. Lactose intolerance is commonly diagnosed, but may be unhelpful in management in the UK because many patients with lactose intolerance have learnt to avoid foods that contain lactose. Unlike irritable bowel syndrome, Crohn's disease is marked by characteristic weight loss, abdominal tenderness or mass with perianal soreness and discolouration. Anaemia and raised inflammatory markers, such as C reactive protein and erythrocyte sedimentation, are tests that discriminate irritable bowel syndrome from patients with other illnesses.

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