Port site metastasis after laparoscopic cholecystectomy

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Abstract We report a case of 62-year-old woman, who developed port site metastasis one year after undergoing laparoscopic cholecystectomy for calculous cholecystitis. This is only second such report in Indian literature.

Keywords Port site metastasis ·
Laparoscopic cholecystectomy

Introduction

Laparoscopic cholecystectomy (LC) is a proven, well accepted surgical technique for the benign disease of gall bladder (GB). Nevertheless, there are increasing reports of seedling of tumour at the trocar sites following laparoscopic cholecystectomy in patients with incidental GB carcinoma. But such reports are rare in Indian literature and only one such case has been reported so far [1].

Case report

A 62-year-old woman underwent LC for calculous cholecystitis. Histopathology examination revealed adenocarcinoma GB (stage T_{1a}). One year later, she presented with lump at subxiphoid port site (Fig. 1). The lump was 7 × 6 cm in size, hard, non tender having nodular surface with ill defined margins and was fixed to skin and underlying structures. Overlying skin was ulcerated and necrotic in patches. FNAC of the lesion revealed adenocarcinoma. Metastatic

Fig. 1 Metastatic lesion at subxiphoid port site

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workup showed liver metastases. Patient was referred to oncology department for further management.

Discussion

A potentially serious complication of LC is the inadvertent dissemination of the unsuspected GB carcinoma. Although the mechanism of the abdominal wall recurrence is still unclear, it is speculated that two major factors may be involved: the systemic progression of the malignancy and the local implantation [2]. Laparoscopic handling of the tumour, perforation of GB, spurting of CO₂ gas containing tumour cells through the port site (so called Chimney Phenomenon) and extraction of the specimen without an endobag may be the risk factors [2].

The true incidence of abdominal wall metastasis after laparoscopic cholecystectomy is unknown [3]. However, many author reported no significant differences between laparoscopic and open surgery in the incidence of wound recurrence [4]. They suggested that the biological aggressiveness of the disease was responsible for port site recurrence [5]. Hence port site metastasis from incidental malignancy should not discourage us from performing lapa-

roscopic surgery. Moreover, port site metastasis does not always indicate advanced disease. It may be localised without any systemic spread and be treated by wide local resection [1]. The use of slow desufflation, avoidance of GB perforation, trocar site wash out and specimen bag for retrieval of GB may further decrease the incidence [5].

Conflict of interest The authors do not have any disclosable interest

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