CARCINOMA GALL BLADDER- AN UNUSUAL PRESENTATION (Case Report)

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Introduction

Pure squamous cell carcinoma of the gall bladder is a rare tumor which may present diagnostic difficulty for the histopathologist. Even more rarely it may be well localized being usually poorly differentiated and rapidly fatal [1]. We present a case of moderately differentiated squamous cell carcinoma of the gall bladder which also had paraneoplastic syndrome in the form of leucocytosis. The patient also had unexplained hypotension which could possibly be due to Tumour Necrosis Factor (TNF).

Case Report

A 50 years old lady was admitted with a painful lump in the right side of abdomen of 6 months duration. The lump had progressively and rapidly increased in size from 3X4 cm to 14X12 cm. There was history of passing altered blood in stool, anorexia and significant weight loss. She was also symptomatic with low grade fever with evening rise. Examination revealed a poorly nourished pale lady with no icterus or generalized lymphadenopathy. There was a very well defined firm to hard, globular right hypochondrial lump, which was moving well with respiration and could be moved across the midline to left lumbar region (Fig. 1). Investigations revealed an Hb of 8.6 g%, TLC 11600/cumm and a non-reactor to ELISA for HIV. Chest X-ray suggested Pulmonary Kochs and patient was exhibited ATT (EHRZ). FNAC was suggestive of Adenocarcinoma. USG showed the lesion to be arising from the gall bladder.

Over a period of 2 weeks during her workup, the TLC count increased to 66000/cumm with a polymorph count of 95%, without evidence of acute infection or high fever. This returned to normal range within 48 hrs post op. The patient also developed unexplained hypotension in the immediate preoperative period which did not respond to adequate IV fluids. However, it spontaneously resolved in the immediate post resection period. In absence of any other corroborative features, these were suggestive of possible paraneoplastic manifestations of the tumour.

Intraoperatively, a large, adherent, globular mass arising from the gall bladder evidently infiltrating the adjacent liver surface and

transverse colon was found (Fig. 2). There were no lymph nodes and no ascites. Gall bladder lumen was obliterated and there were no stones. A Radical Cholecystectomy with en-block removal of the adherent colonic loop and the adjoining liver was carried out

Fig. 1 : Preoperative photograph of the patient showing the well defined lump in the abdomen

Fig. 2 : Intraoperative photograph showing the lump adherent to the transverse colon. Radical cholecystectomy was done

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Fig. 3 : Scanner view showing normal gall bladder mucosa on the right. Clumps and sheets of malignant squamous cells are seen undermining the mucosa in the left half of the field.

with primary end to end anastomosis of the transverse colon. Post op recovery was uneventful. Patient has been under regular follow-up, and is well.

Histopathological examination reported a 17X9 cm irregular greyish white tumour mass, with haemorrhagic and cystic foci. The cut surface showed a nodulo-ulcerative thickening filling the body and the fundus of the gall bladder with a small expanse of adherence to liver tissue and gut. Microscopic examination showed keratinisation along with pearl formation suggestive of squamous cell carcinoma of the gall bladder which was moderately differentiated (Figs. 3 & 4).

Discussion

Squamous cell carcinoma of the gall bladder is an uncommon histological variant. It accounts for less than 5% of all types of gall bladder carcinomas, the commonest being adenocarcinoma-85%. When present, it is usually undifferentiated and follows a relentless, aggressive course. However, in our patient, the tumor was very well localized, mobile, with no evidence of metastasis. It was a clinical diagnostic dilemma until the USG showed the lesion to be arising from the gall bladder.

There was a leucocytosis of 66,000/cumm with no evidence suggestive of abscess, collection or necrosis. This paraneoplastic syndrome has been reported with squamous cell carcinomas of the lower jaw, lung, thyroid and other tissues, but rarely with gall bladder carcinoma [2]. This is associated with tumor production of growth factors including GM-CSF, G-CSF, IL-3, IL-1 and various other mediators [3,4].

Unexplained hypotension in malignancy in the absence of septicemia, necrosis or hypovolemia is an inadequately studied topic in surgical literature. In our case, the hypotension subsided almost immediately following resection of the tumour. We suggest that this may be explained by 'Tumor Necrosis Factor',

Fig. 4 : Low power view showing flattened low columnar epithelium to the right and zone of malignant squamous transition near the left border

evidence in favour of which is growing but little published data exists.

Chemotherapy and radiation therapy have questionable benefits. In our case, we neither advised nor could she afford it. Prognostically, malignancy of gall bladder is associated with dismal outcome. About 88% die within about a year of diagnosis and only 4% are alive after 5 years, in a review of 6,000 patients [5]. Only 7% with serosal invasion are alive at 5 yrs [6]. Besides, squamous cell carcinoma of the gall bladder tends to behave as anaplastic. Our case was also reported with serosal invasion.

In conclusion, the rarity of squamous cell carcinoma of gall bladder and even more rare association of paraneoplastic manifestations of severe leucocytosis and unexplained episodic hypotension, both resolving after surgical removal, prompted us to report this as an interesting case.

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