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## Oncology

# A case of primary squamous cell carcinoma of the gallbladder with local invasion of the liver and peritoneum, and metastasis to the omentum

Asaph C.J. Levy<sup>a,\*</sup>, Francisco Casalduc-Coca<sup>a</sup>, Saeed Asiry<sup>b</sup>, Allen Goodman<sup>a</sup><sup>a</sup>Department of Radiology, Northwell Health System, Lenox Hill Hospital, 100 East 77th St, New York, NY 10075 USA<sup>b</sup>Department of Pathology, Northwell Health System, Lenox Hill Hospital, New York, NY USA

## ARTICLE INFO

## Article history:

Received 17 August 2017

Received in revised form 11

September 2017

Accepted 25 September 2017

Available online

## Keywords:

Primary

Squamous

Cell

Carcinoma

Gallbladder

Cancer

## ABSTRACT

Primary squamous cell carcinoma of the gallbladder is a rare entity that comprises approximately 1%-3% of all primary gallbladder cancers. We report the case of a 37-year-old woman who was diagnosed with a locally invasive squamous cell carcinoma of the gallbladder. Surgical pathology revealed a predominantly squamous cell carcinoma composition of the tumor with a few microscopic foci of adenocarcinoma (<1% of tumor). We discuss pertinent clinical features, risk factors, and imaging characteristics to prompt early diagnosis and treatment, which will ultimately lead to improved patient outcomes.

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## Introduction

Gallbladder cancer (GBC) is the fifth most common gastrointestinal tract malignancy in the United States, with an incidence of 6500 cases annually [1]. Known risk factors for GBC include chronic cholelithiasis, female gender (ratio approximately 3:1), porcelain gallbladder, adenomatous polyposis of the gallbladder (GB), carcinogens (eg, miners exposed to radon), *Salmonella typhi* infection, and abnormal pancreaticobiliary duct junction [1]. Although only up to 3% of patients with cholelithiasis develop

gallbladder cancer, gallstones are present in 70%-90% of patients diagnosed with GBC [1]. Chronic irritation of the GB wall related to gallstones is hypothesized to be the major risk factor for malignant transformation of the GB epithelium. Approximately 80%-95% of primary gallbladder cancers are adenocarcinoma (AC) [2]. Other histologic types include small cell cancer, squamous cell carcinoma (SCC), lymphoma, and sarcoma.

Patients with GBC are usually asymptomatic in the absence of advanced disease. As a result, diagnosis and management can be challenging. Patients can often present with symptoms such as anorexia, abdominal pain, nausea, and vomiting,

Declaration of Interest: We certify that there are no financial or personal relationships with other people or organizations that could inappropriately influence our work. We certify that this is an original manuscript, which has not been published elsewhere.

\* Corresponding author.

E-mail address: [asaphlevy@gmail.com](mailto:asaphlevy@gmail.com) (A.C.J. Levy).

<https://doi.org/10.1016/j.radcr.2017.09.026>

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which may be indistinguishable from those of acute cholecystitis [3]. Findings that are more specific for advanced disease include weight loss, obstructive jaundice (secondary to tumor invasion of the intrahepatic bile ducts or hepatic metastases), ascites, palpable abdominal mass, and hepatomegaly. Computed tomography and ultrasonography results are often consistent with acute cholecystitis and cholelithiasis. Thus, most cases are diagnosed intraoperatively.

### Case report

A 37-year-old previously healthy Caucasian female presented initially with progressive right upper quadrant (RUQ) abdominal pain and pruritus. Her pain became increasingly worse 2 days prior to presentation. Review of systems revealed jaundice, scleral icterus, pruritus, fatigue, light-colored stools, and progressive abdominal distension, despite not having made any dietary modifications. She did not report weight loss, fever, chills, nausea, or vomiting. Social history reveals social alcohol consumption and a light tobacco smoking history. On examination, she was jaundiced, with a palpable RUQ mass. Her abdomen was soft and nontender. Laboratory findings demonstrated a WBC count of 7100/ $\mu\text{L}$  (normal: 3.8-10.5 K/ $\mu\text{L}$ ), total bilirubin (T. Bili) of 7.3 mg/dL (Normal: 0.2-1.2 mg/dL), direct bilirubin (D. Bili) of 5.7 mg/dL (Normal:  $\leq 0.2$  mg/dL), alkaline

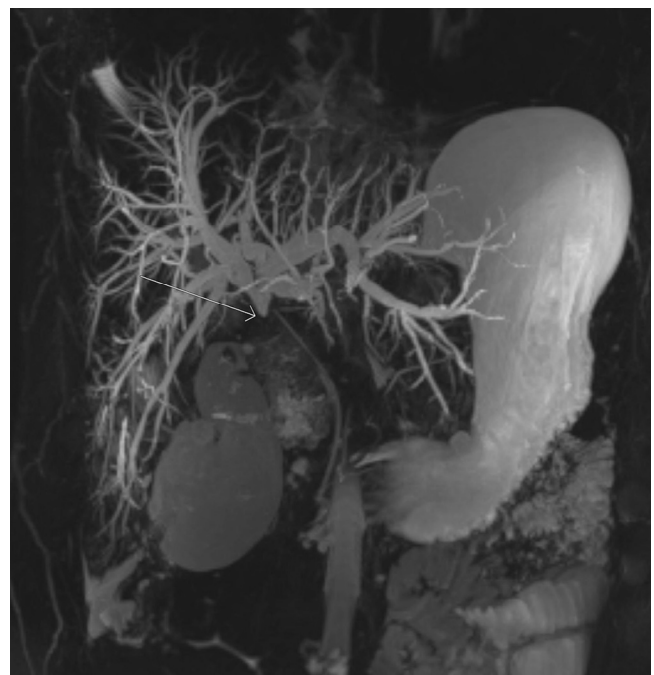


**Fig. 1 – Coronal contrast-enhanced CT image of the abdomen demonstrates gallbladder wall thickening, pericholecystic hepatic lesions (tumor invasion), intrahepatic biliary ductal dilatation, as well as a soft tissue peritoneal lesion adjacent to the gallbladder (arrow). CT, computed tomography.**



**Fig. 2 – Axial contrast-enhanced CT image demonstrates large hypodense hepatic lesions, a distended gallbladder neck with stones (arrow), and intrahepatic biliary ductal dilatation. CT, computed tomography.**

phosphatase (Alk Phos) of  $>1000$  U/L (Normal: 40-120 U/L), and Ca 19-9 of 45.0 U/mL (Normal:  $\leq 41.3$  U/mL). The initial computed tomography scan of the abdomen was interpreted to include intrahepatic biliary ductal dilatation, a dilated stone-filled GB up to 6.4 cm in diameter with an abnormally thickened wall up to 0.6 cm, and pericholecystic fluid, which was concerning for acute cholecystitis or choledocholithiasis. There was also an 8.4 cm heterogeneous soft tissue mass within the liver with an infiltrative component adjacent to the GB fossa (Figs. 1 and 2). A corresponding MRI demonstrated a focal defect in the



**Fig. 3 – Coronal T2-weighted MIP image of the biliary tree demonstrating CHD obstruction (arrow). CHD, common hepatic duct; MIP, maximum intensity projection.**

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