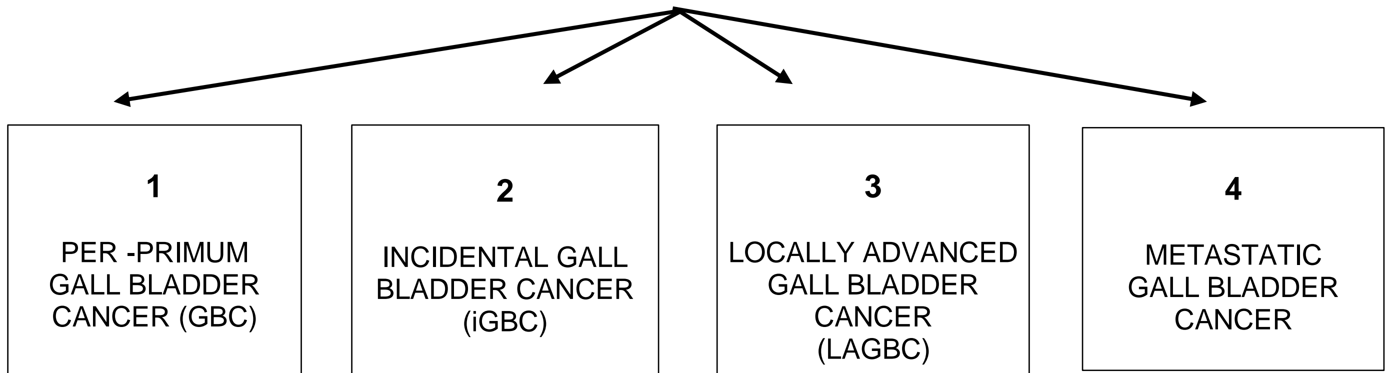
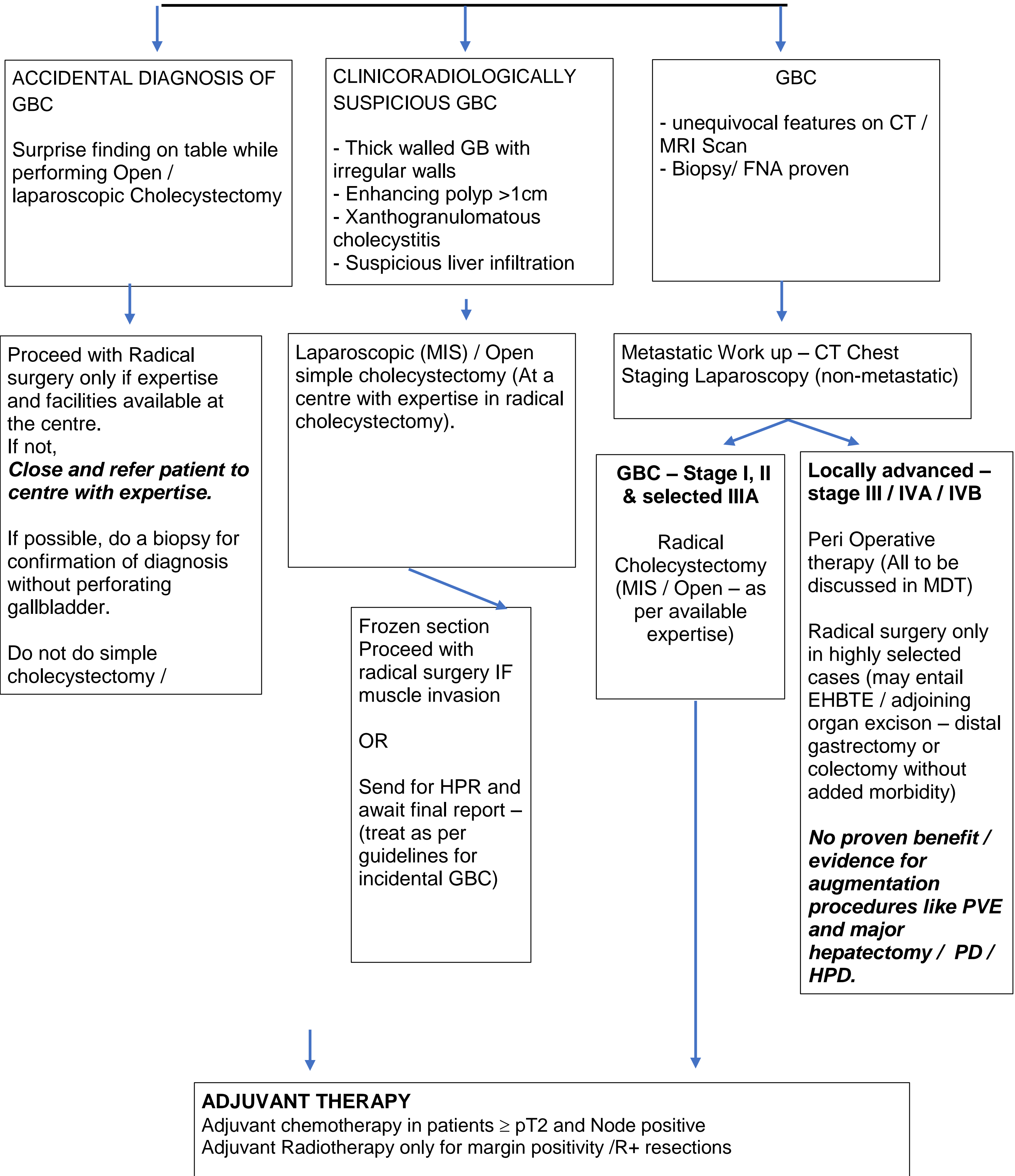
GALL BLADDER CANCER

BASIC WORK UP

Ultrasonography
Blood Investigations: Liver function tests, Tumour markers – CA 19-9
CECT Scan of Chest Abdomen and pelvis
US / CT guided biopsy – if upfront surgery not contemplated/ metastatic disease
Optional: MRI with MRCP in patients presenting with OJ
Whole body PET CECT Scan.



1. PER PRIMUM GBC



RADICAL/EXTENDED CHOLECYSTECTOMY : encompasses removal of Gall bladder along with excision of GB fossa of the Liver – minimum 2.5 cms wedge of liver (extended) or formal segment 4b & 5 (radical) and flush ligation of cystic duct with bile duct (frozen section regulated negative cystic duct margin) along with periportal and retroduodenal nodal clearance – station 8, 12 and 13

Para aortic lymph nodal sampling (station 16) should be done before proceeding to radical surgery.

2. INCIDENTAL GBC (iGBC)

Diagnosis of Gallbladder cancer based on post operative histopathology of the gallbladder specimen in a case where chlolecystectomy (Laparoscopic or open) done for a presumed benign gall bladder pathology

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Complete metastatic work up: CT Chest abdomen pelvis / *PET CT if presenting after 6 w*eeks
Repeat all labs + Tumour marker CA 19-9
Review of Histopathology – Ideally entire gallbladder to be processed. Note T stage, cystic duct margin and cystic node
Diagnostic laparoscopy if presenting after 4 weeks prior to definitive surgery.

pT1b and above
Stage I, II & selected stage IIIA

Revision Surgery - Revision Radical / Extended Cholecystectomy

pT3, T4 and N + patients
Stage III, Stage IVA & IVB

Peri-Operative treatment

To be treated as Locally advanced GBC.

Adjuvant Chemotherapy as per Stage

There is no upper and lower time limit for Revision Surgery. Should be done as early as possible and whenever feasible.

No level I or II evidence for Neoadjuvant RT – should be done in trial setting only.

Revision Surgery : Essentially same as Radical cholecystectomy, however, it is important to revise the cystic duct stump to confirm margin negativity on frozen section.

EHBTE can be performed to obtain negative margins or for complete nodal clearance if nodes are densely adherent to bile duct, however routine excision of bile duct is not recommended.

Para aortic lymph nodal sampling is recommended before proceeding to curative surgery

3. LOCALLY ADVANCED GBC (LAGBC)

Identifies high risk group GBC which are likely to relapse or fail at distant sites.

Clinical T 3,4 and any T with node positive disease – stage III and IVA, IVB OR
iGBC with evidence of residual or recurrent disease with no clinic-radiological evidence of distant metastasis

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CBC Creatinine, CA 19-9, LFT
Obtaining tissue diagnosis: Biopsy/ FNAB is mandatory to confirm diagnosis
Staging: *Whole body PET CECT Scan*
CECT Scan - Chest, Abdomen and Pelvis

In patients presenting with OJ:
Rule out OJ due to stone disease
MRCP to ascertain the exact level of block

Drainage –
Lower CBD block due to nodal compression – ERCP with plastic/ SEMS placement.
For type I / type II communicating block with roof intact – plastic stent / short SEMS ERC/PTBD
For type II non communicating /III/IV block – Only PTBD , bilateral / unilateral SEMS

Locally advanced unresectable disease unlikely to come up for curative resection

Hilar infiltration with involvement of porta hepatis/ hilar plate with OJ – Type II non communicating block or III / IV block
Encasement of main PV/LPV/CHA

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Chemotherapy with palliative intent.

Can add Radiotherapy as a definitive treatment modality for local control, in absence of metastatic disease

Locally advanced resectable disease or likely to come up for curative resection

T3, 4 disease, N+
Type I or II communicating block
No Main vessel or contralateral vessel encasement

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Staging laparoscopy (optimal)

Upfront surgery – Radical cholecystectomy / Revision surgery.
- May entail adjacent/involved organ excision like EHBTE, Distal Gastrectomy or Colectomy

Major resections like hepatectomy, Pancreatoduodenectomy or HPD can be performed in highly selected cases with excellent performance status and good tumor biology

(PREFERRED PATHWAY)

Neoadjuvant chemotherapy – Gemcitabine + Cisplatin (3 – 4 #)
OR
Neoadjuvant Chemo-Radiotherapy (only in trial setting)

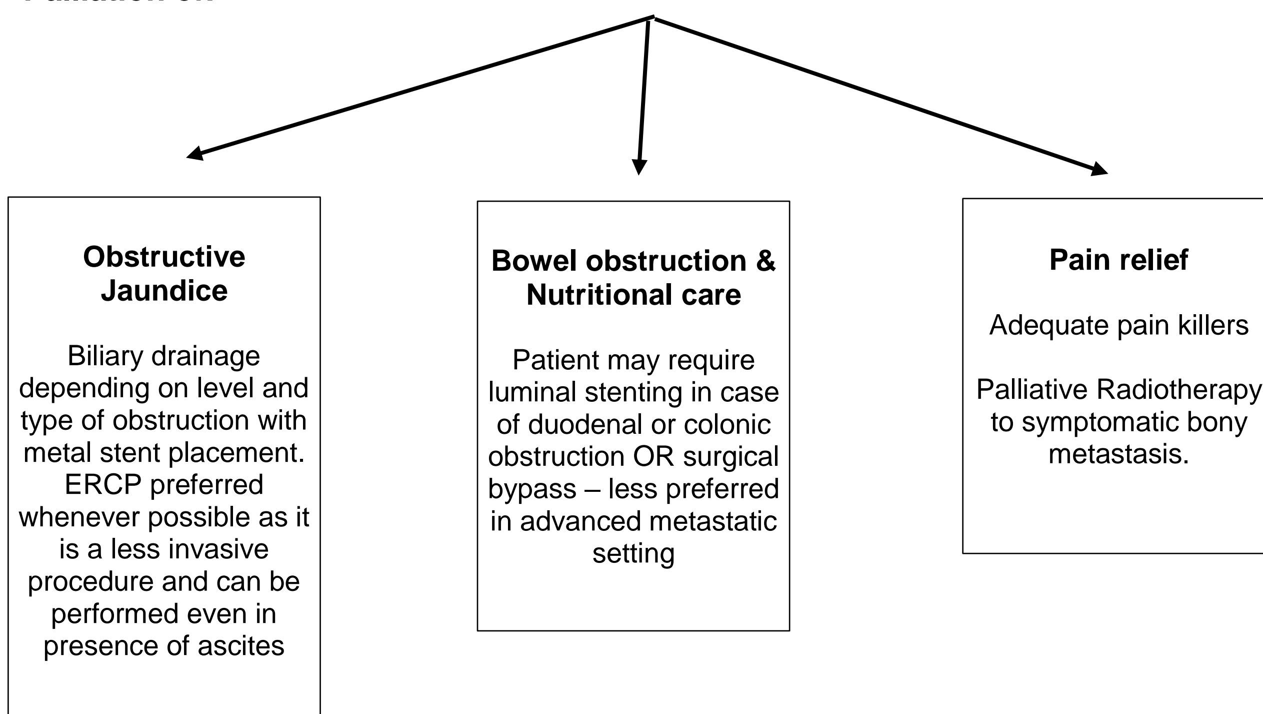
Reassess for possible curative resection

If unresectable or metastatic (PD) – continue palliative chemotherapy
OR
Radical Cholecystectomy / Revision

Adjuvant Chemotherapy

4. METASTATIC GBC

Palliation of:



Palliative chemotherapy – (to add additional IHC, if not confirmed to be an adenocarcinoma on morphology)
1st line chemotherapy: (level I) Gem Cis 3 weekly till progression , response assessment after every 3 to 4 cycles.
(level IIB): Gem cis nab paclitaxel combination

2nd line chemotherapy (level IIB) :
Fluropyrimidine and or irinotecan / oxaliplatin based chemotherapy
Regorafenib
Bevacizumab erlotinib (Level IIB/III).

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