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Gall Bladder Cancer – The Indian Perspective

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Abstract

Gall bladder cancer (GBC), uncommon in the West (USA, UK and Australia), is common in north India – the incidence in women in Delhi being more than 9 per 100,000 per year as compared to less than 1 per 100,000 in the West as well as in south India; it is the fourth commonest cancer (following breast, cerivx and ovary) and the commonest gastrointestinal cancer in women in Delhi (NCRP 2002). In our experience, it is the commonest cause of malignant surgical obstructive jaundice – as many as 74 (51%) out of 145 patients with malignant surgical obstructive jaundice seen by us between 1989 and 1992 had GBC (Sikora EJSO 1994).

The usual and typical clinical presentation of GBC is with dull continous right upper abdomen pain, progressive jaundice, anorexia and weight loss and palpable GB mass. These are, however, features of advanced disease which is usually unresectable. Early – resectable and curable – GBC is an elusive disease – difficult to differentiate clinically from gall stone disease (Kapoor JSO 1996) and may not be detected even on ultrasonography (US). Out of 14 patients with early (Stage I) GBC, only 3 were diagnosed preoperatively and another 3 were diagnosed at surgery; GBC was detected incidentally on histology in 8 patients (Wagholikar JACS 2002). Some patients with GBC present with atypical features eg mucocele, empyema, acute cholecystitis and liver abscess and may have unusual associations eg CBD stones, intestinal obstruction/ bleeding (Haribhakti TrGE 1997).