GASTRIC INVASION OF CARCINOMA OF THE GALLBLADDER
CAUSING HEMATEMESIS

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ABSTRACT

Carcinoma of the gallbladder remains one of the most deadly and aggressive cancers. Although patients may have surgical extirpation of the disease and undergo adjuvant treatment, recurrence is common with poor long-term results. Invasion of the liver with rapid spread is the usual course.

Case Report

A 48 year-old woman underwent laparoscopic cholecystectomy with an incidental pathologic finding of carcinoma of the gallbladder. The patient returned to surgery for wedge hepatectomy with clear pathologic margins. She was treated with adjuvant 5-fluorouracil and radiation and followed closely. Five months after her initial surgery, two cycles of cisplatin and 5-fluorouracil were given for recurrent hepatic carcinoma. She then presented to the Emergency Department with hematemesis. Her admission hemoglobin was 5.6 g/dL. Emergent endoscopy revealed an extensive invasion of the gastric antrum with ulceration, cloting and loss of domain of the stomach. The duodenum had no apparent involvement.

Case Report

The patient was transfused and an arteriogram was ordered. The gastroduodenal artery was embolized as a palliative maneuver. No acute arteriographic bleeding was identified. A portion of the tumor blood supply was noted to be from the inferior pancreatico-duodenal branch of the superior mesenteric artery which was not amenable to embolization.

The patient stabilized, had no further acute bleeding and was discharged on Carafate for mucosal ulceration. She then continued outpatient palliative chemotherapy.

Discussion

This rare presentation of acute upper gastrointestinal hemorrhage highlights the aggressiveness of the disease. The diagnosis is frequently made after routine cholecystectomy, prompting further surgical treatment which may involve lymph node dissection or partial hepatectomy. Adjuvant chemotherapy can prolong life but is commonly ineffective. Gastrointestinal invasion when reported is usually to the duodenum which is in closer proximity to the gallbladder. Clinicians should be aware of this possibility when patients with gallbladder carcinoma are seen with findings of gastrointestinal bleeding.

The patient’s endoscopy photographs shown above indicate near-circumferential infiltration of the antrum and extensively ulcerated mucosa but no active hemorrhage. CT images shown below after recurrence reveal significant infiltration of the liver and loss of the plane between liver and stomach, with apparent infiltration of the distal stomach wall.

After evaluation and considering the extent of her gastric invasion by both CT and endoscopy images, we felt that a palliative resection of her stomach for future rebleeding would be extremely morbid. Embolization of her gastric arterial supply was performed as seen in the images below. She has had no further bleeding after two more cycles of chemotherapy.

SUMMARY

Gallbladder carcinoma remains a clinical challenge. Difficulty in making the initial diagnosis at a treatable stage and rapid spread contribute to a median survival rate of about six months for this malignancy.

Acute bleeding caused by gallbladder carcinoma invading the stomach is rare. One other presentation of hemorrhage from the “pyloric canal” is reported in the literature without endoscopy photographs for review; it is unclear whether the carcinoma in that case involved the duodenum or stomach.

We believe embolization of the gastroduodenal artery helped prevent further catastrophic bleeding in this patient with extensive ulceration of stomach mucosa by tumor. Physicians should be aware of this treatment option and the possibility of proximal gut invasion of carcinoma of the gallbladder.

BIBLIOGRAPHY