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Gall Bladder Carcinoma

1. GROSS DESCRIPTION

Specimen

— gall bladder disease presents generally in middle-aged to elderly females with dyspepsia, bloating and right hypochondrial pain. Investigation includes liver function tests and abdominal ultrasound scan looking for luminal/mural lesions, calculi or large duct obstruction. If abnormal, CT scan and cholangiography [percutaneous or at endoscopic retrograde cholangiopancreatography (ERCP)] are of use in demonstrating and staging a tumour mass.
— laparoscopic/open cholecystectomy. Most gall bladder cancers are an incidental finding after routine cholecystectomy. Rarely, they are submitted as part of an elective extended cholecystectomy—after determination of the extent of local spread by operative ultrasound the hepatic gall bladder bed and regional nodes are resected. A deeper tumour may require hepatic segmental resection.
— size (cm) and weight (g).
— open/intact.
— contents: bile/calculi (number, size, shape, colour).
— lymph nodes: site/size/number.

Tumour

Site

— fundus (50%)/body/cystic duct.

Size

— length × width × depth (cm) or maximum dimension (cm).

Appearance

— grossly apparent/inapparent.
— diffuse (65%)/polypoid (30%—including papillary)/ulcerated.

Edge

— circumscribed/irregular.

2. HISTOLOGICAL TYPE

More than 90 % of gall bladder cancers are adenocarcinoma.

Adenocarcinoma

— tubular/acinar: usual type and a well to moderately differentiated biliary pattern of low cuboidal to tall columnar cells.
— papillary: polypoid/well differentiated/better prognosis.
— intestinal/mucinous/signet ring cell/clear cell: unusual. Distinguish from metastatic stomach or bowel cancer by adjacent mucosal dysplasia. Mucinous/signet ring cell carcinomas require >50% of the tumour to be composed of this pattern.

Adenosquamous carcinoma

Squamous carcinoma

Small cell carcinoma

— and other neuroendocrine lesions, e.g. carcinoid/large cell neuroendocrine carcinoma including composite tumours (carcinoid/adenocarcinoma).
— small cell carcinoma is aggressive and may be a component of usual adenocarcinoma.

Spindle cell carcinoma/carcinosarcoma

— biphasic carcinoma/sarcoma-like components ± specific mesenchymal differentiation. These represent carcinomas with variable stromal differentiation and overlap with undifferentiated carcinoma.
— elderly patients, poor prognosis.

Undifferentiated carcinoma

— nodular and solid/spindle cell/giant cell/osteoclast-like giant cell variants.

Malignant melanoma

— secondary (15% of disseminated melanoma at autopsy) or rarely primary (nodular, adjacent mucosal junctional change).

Metastatic carcinoma

— direct spread: stomach, colon, pancreas, cholangiocarcinoma.
— distant spread: breast, lung, kidney.

Note that cystic duct carcinoma is classified as a tumour of the extrahepatic bile ducts.

3. DIFFERENTIATION

Well/moderate/poor/undifferentiated, or Grade 1/2/3/4 based on the percentage tumour gland formation (well/G1 >95%; moderate/G2 50–95%; poor/G3 <95%).