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An Overview on Incidental Gallbladder Cancer

Anand Kulkarni*

Department of Pathology, Asian Institute of Gastroenterology, Hyderabad, India

***Corresponding author:** Anand Kulkarni, Department of Pathology, Asian Institute of Gastroenterology, Hyderabad, India, E-mail: anandkulkarni@hotmail.com

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Description

Gallbladder Cancer (GBC) is a rare but fatal illness in the United States, with an annual incidence of less than 5000 new cases. Preoperative diagnosis is only found in about 20% of GBC patients. The remaining instances are identified either after a laparoscopic cholecystectomy or during the procedure. GBC is detected by chance during histopathology following 0.25%–3.0% of laparoscopic cholecystectomies, although it accounts for 74%–92% of all GBC. Accurate patient staging is the most crucial and vital phase. Staging determines how a disease should be managed and what therapy choices are available, as well as predicting survival. Because GBC is deadly and has a poor prognosis, curative surgery is confined to resectable disease.

The most frequent elective operation performed worldwide is laparoscopic cholecystectomy. For all symptomatic gallstone disorders, it is considered as a standard therapy. The absence of a serosal layer between the gallbladder and the liver, as well as the anatomy of the gallbladder, allow GBC to invade the liver rather early. GBC has a proclivity for spreading to lymph nodes and peritoneal surfaces hematogenously. Furthermore, due to its vague presentation and constellation of symptoms and indications, many of which are shared with benign conditions like biliary colic or chronic cholecystitis, GBC is often misdiagnosed until it is well advanced. The remaining cases are identified either after a laparoscopic cholecystectomy or during the procedure. These cases are referred to as "incidental GBC," and their treatment is more complicated and difficult.

GBC can be identified during or after a cholecystectomy if a suspicious mass is discovered. The majority of these cases are discovered during a laparoscopic cholecystectomy for symptomatic gallbladder stones. This is a risk factor for re-exploration to discover the existence of probable residual disease, which changes the course of disease management dramatically. Gallbladder masses discovered after cholecystectomy should be treated by a competent hepatobiliary surgeon. If there isn't a specialised surgeon available, the cholecystectomy should be postponed and the patient referred to a specialised centre.

The traditional postsurgical technique is to histopathologically examine every tissue to document any concerns about the diagnosis and rule out any oncological cause. In high-incidence areas, microscopic inspection of at least three sections is advised. The expense and workload increase caused by pathologists evaluating specimens from the most often performed operation in the world is controversial. This technique, however, may result in the diagnosis of GBC in 0.25%–3.0% of all samples tested. On the basis of red flags in the perioperative period, radiological imaging, and macroscopic evaluation of the gallbladder, several studies propose selective histological analysis of the gallbladder.

The most prevalent indications of gallbladder cancer are gallbladder wall thickening and mucosal ulceration. However, there is currently a lack of evidence to back up such a procedure.

GBC is a cancer that is both rare and fatal. The majority of cases are identified by chance while treating a benign condition, emphasising the significance of a histological examination following all cholecystectomies. Although therapy for GBC can be multimodal, surgical surgery is the standard method. Accurate preoperative staging is the most crucial and vital phase. Staging determines how a disease should be managed and what therapy choices are available, as well as predicting survival. Patients should be participated in ongoing multicenter clinical studies due to the disease's rarity.