SYNCHRONOUS ADENOCARCINOMA OF GALL BLADDER AND AMPULLA OF VATER

AURANGZEB, ANSAR LATIF

ABSTRACT *A case of synchronous adenocarcinoma of gall bladder and ampulla of Vater is presented, which was preoperatively diagnosed as carcinoma of ampulla of Vater. Whipple's resection was performed. Intraoperatively there was no evidence of any synchronous tumour on gross examination but histopathology report turned out to be that of adenocarcinoma of gall bladder and ampulla of vater.*

Key words Carcinoma ampulla of Vater, Synchronous double cancer, biliary tract carcinoma.

INTRODUCTION:
In surgical practice, many a times we come across malignant disease and on some occasions these lesions present at more than oneÊ places / or organs at the same time i.e synchronous or there may have some interval of time between the two presentations, i.e metachronous. Synchronous/metachronous tumours may be benignÊ at one place and malignant at other or both.[1] Periampullary carcinomas are not rare and may presentÊ synchronously with adenocarcinoma of gall bladder in biliary tract or at other places like stomach and colon. These tumours are usually malignant. Ampullary cancer is the second most common periampullary cancer, with a resection and survival rate more favourable than that for pancreatic cancer as it usually presents with symptoms in the early stage of disease.[2]

ERCP remains the important management tool for pathologies of this location.[3] The only curative treatment in biliary tract cancer is surgical treatment i.e. pancreaticoduodenectomy but transduodenal local resection is a comparable mode of operation for low-risk-group patients with ampulla of Vater carcinoma. In particular, it is essential to evaluate the invasion depth in preoperative endoscopic ultrasonography, cell differentiation in preoperative biopsy, and positive resection margin accurately by using frozen section during the operation.[4]

CASE REPORT:
A 65 years old lady was admitted to medical ward with dyspeptic symptoms. She was being treated with proton pump inhibitors. On abdominal ultrasonography, a 2 cm diameter growth of mpulla of Vater causing dilatation of common bile duct found. CT scan abdomen and pelvis confirmed the sonographic findings. There was no ascites,Êlymphadenopathy or metastasis in the liver.

Patient was prepared for curative resection and pancreaticoduodenectomy was planned. At laparotomy all parameters of curative resection were confirmed and pylorous preserving pancreaticoduodenectomy was performed. Pancreaticojejunostomy, choledocho-jejunostomy, gastrojejunostomy and feeding jejunostomy were done to restore the gastrointestinal continuity. Postoperative recovery and progress was smooth.

The resected specimen inclusive of gallbladder, CBD, duodenum, part of jejunum, pancreatic head neck and part of body along with growth were sent for histopathology. The report showed well-differentiated adenocarcinoma – periampullaryÊ region and of gallbladder. At present, patient is on adjuvant chemoradiotherapy.

DISCUSSION:
Ampullary cancer is the second most common periampullary cancers with a resection and survival rate more favorable than that for pancreatic cancer.[2] Many patients surviving at least 5 years seem to be cured by surgical resection. Patients usually present with jaundice, weight loss, dyspepsia or abdominal pain or rarely palpable mass abdomen or fluctuating diabetes (fluctuation in jaundice and diabetes is due to sloughing of tumour) and these patients have occult blood in stools. Our patient presented with dyspepsia and ultrasonography lead to diagnosis. Multidetector computed tomography (MDCT), in particular- one of the methods of enhanced CT- is useful for decision of surgical criteria, because MDCT shows findings such as localization nd extension of the tumour, a and the presence or absence of remote metastasis. Neither

Correspondence
Dr. Ansar Latif
Department of Surgery
Combined Military Hospital,
Sialkot Cantonment.

definite methods for early diagnosis nor specific markers are available in this disease. Tumour markers like CEA, CA19-9 may give a clue to diagnosis but CA19- 9 has more specificity. Laparoscopy may be undertaken in patients with highly suspicious biliary and pancreatic lesions to facilitate diagnosis and staging cancer.[5] If an unresectable tumor is identified, a second endoscopic procedure may be required to deploy a self-expandable metal stent (SEMS) for palliaton.

The only curative treatment in biliary tract cancer is surgical excision.[5] Therefore, the suitability of curative resection should be investigated in the first place. No definite consensus has been reached on local extension factors and curability. The patients who fullfil the criteria of curability undergo pylorous preserving pancreaticoduodenectomy. The advantage of pylorous preserving pancreaticoduodenectomy isÊ to avoid weight loss, dumping syndrome and diarrhea. Other more aggressive resections like total pancreaticoduodenectomy for chance of multicentricity or in diabetics, extended Whipple resection for involved vessels are practiced rarely. Transduodenal local resection is a comparable mode of operation for low-risk-group patients with ampulla of Vater carcinoma.

Carcinoma of the ampulla of Vater has a more favorable prognosis, compared to other malignant tumors of the periampullary region, because it usually presents with symptoms in the early stage; grow slowly and tend to remain localized.[6] However, treatment by local resection only of the ampullary carcinoma remains controversial. Preoperative biopsy and intraoperative frozen section analysis have limitations in the management of patients undergoing ampullectomy.[7] Endoscopic mucosal resection (EMR) is a technique used to locally excise lesions confined to the mucosa. Its role has expanded as a therapeutic option for ampullary masses,[8] colorectal cancer, and large colorectal polyps.

Self-expanding metal bile duct stents provide good palliation for inoperable malignant disease but can be problematic.[9] A proportion of cases will have benign strictures and in others the confirmation of malignancy may be made more difficult. TheÊ role of adjuvant chemordiation therapy (CRT) in the treatment of ampullary cancers remain undefined who underwent potentially curative pancreaticoduodenectomyÊ and also recived adjuvant CRT.[10] Ampullary cancers have a distinctly better treatment outcome than pancreatic adenocarcinomas. The purpose of radiation therapy for unresectable biliary tract cancer is to prolong survival or prolong stent patency, and to provide palliation of pain.[11] The long-term relief of jaundice is difficult without using biliary stenting, a combination of radiation therapy and stent placement is commonly used.

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