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Thick Walled Gall bladder and Gall Bladder Malignancy: Management Options for Surgeons

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Gall stone disease can have varied presentations. In presence of thick walled gall bladder there is a challenge to differentiate benign diagnosis from malignant diagnosis preoperatively & to prove or rule out malignancy .In case of long history of stones, old age, familial risk factors, presentation with jaundice, anorexia there are more chances of thick walled GB being malignant pathology. There are imaging features in USG which point towards malignant or benign causes of gall bladder wall thickening. If suggestive features of history, physical examination and USG are combined carefully and level of suspicion is high one must get cross sectional imaging done and evaluate the patient with tumor markers like ca19-9 to confirm or rule out malignant diagnosis. Simultaneously it's also true that having thick walled Gall bladder doesn't always mean a malignant diagnosis.

In our experience most of cases which turn out to be malignancy of gall bladder coexisting with Gall stone disease are patients who have-long history of years of diagnosis of Gall Stones, age > 60 yrs, USG suggesting irregular thick wall/mass at one part of gall bladder. There are features which can help a surgeon differentiate and decide plan of management based on preoperative and intraoperative criteria. In USG If there is circumferential thickening <4 mm one must consider it as benign diagnosis and can proceed with simple laparoscopic cholecystectomy.

If there is >4 mm wall thickening and uniform circumferential thickening then CECT should be done. In case CECT shows well enhancing circumferential thickening then one can perform laparoscopic cholecysyectomy with attempt to do it without opening the gall bladder and low threshold of open surgery if suspicion of malignant diagnosis is high intraoperatively with removal of gall bladder in end bag. Preoperative counseling of patient regarding +/- need of frozen section or imprint cytology followed by +/- need of radical cholecystectomy in case of malignant diagnosis is made. Preoperative information to pathologist about chances of need have frozen or imprint cytology to prove malignant diagnosis should be done in such case. One must be prepared to perform radical cholecystectomy with segment 4b+5 resection with standard lymphadenectomy in thick walled GB case as and when diagnosis of malignancy is confirmed.

If there is >4mm irregular wall thickening CECT is a must and if presence of mass is confirmed in CECT then case should be dealt with as malignant GB case and all consents, counseling and surgical planning should be clearly done as for cancer GB case. But one should certainly explain the possibility of negative final diagnosis upto 5-10% and must document the explanation to the patient in consent. As most of the responsibility of diagnosis of malignant vs. non malignant thick walled GB lies on surgeons shoulder, surgeon should have sound knowledge about such cases and a clear plan of action should be made.

In case of >4mm thick walled GB in sick, aged< 70 yrs ,high risk patient with cardiac /respiratory factors, then we plan laparoscopic surgery but very low threshold for open cholecystectomy with wait for final biopsy of gall bladder specimen and keep the radical surgery plan for the second stage after confirm diagnosis, in such sick patients. It saves radical cholecystectomy being done in aged, sick patient as well as frozen /imprint cytology can be false negative in 25-50% cases respectively, when stage is T1A/T1B in final biopsy these patients can be given option of completion ccx vs. adjuvant chemotherapy as per their general condition and family wishes. In our department, our policy in such cases is to perform only cholecystectomy when gross liver surrounding invasion is absent.

Sometimes such a simple and widely performed surgery of gall bladder stones get complicated when diagnosis of thick walled gall bladder is made and decision making is sometimes difficult .One must keep egos aside, decide in favour of patient and in favour of radical cure without harming patient by morbidity /mortality.

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