Umbilical Port Site Metastasis Following Laparoscopic Removal Of Gallbladder With High Grade Dysplasia

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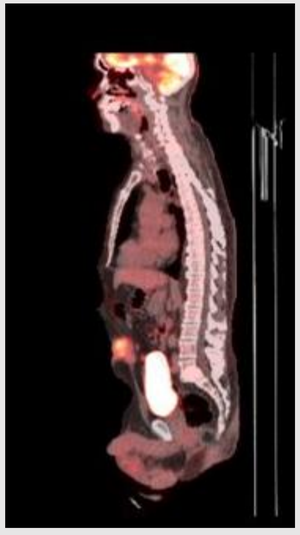
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Introduction

- Unsuspected gallbladder carcinoma, defined as malignancy confirmed after cholecystectomy for benign disease, has an incidence of approximately 3%.
- The incidental histopathologic finding of dysplasia without invasive carcinoma on routine cholecystectomy is poorly described due to its variable incidence which can be as low as 0.25% [1].
- Discovery of a metastatic lesion in the years following resection of a gallbladder with epithelial dysplasia is undocumented to our knowledge.

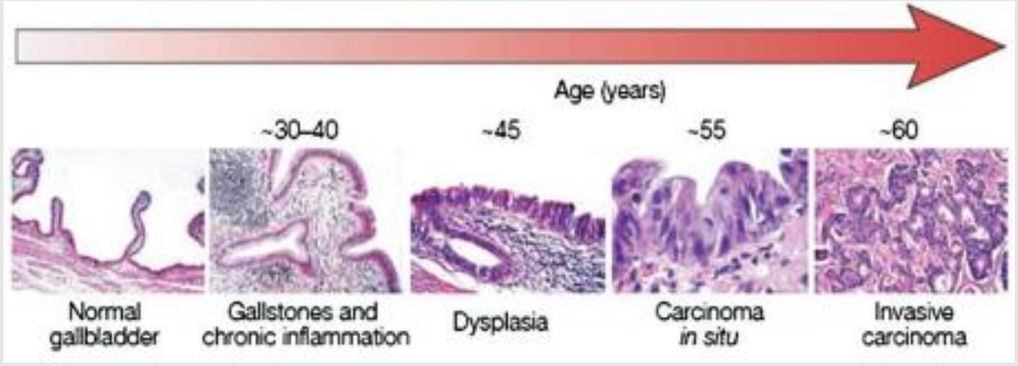
Case

73-year-old male status-post routine Laparoscopic Cholecystectomy with pathology significant only for multifocal high-grade dysplasia, returned to the operating room three years later for removal of suspected painful fibrotic tissue at the umbilical port site. That tissue pathology revealed metastatic adenocarcinoma of unknown origin but suspected pancreaticobiliary or upper gastrointestinal tract origin based on tissue markers. Oncologic workup with EGD, Colonoscopy and CT/PET scan failed to identify any primary lesion, but did show residual tumor at the umbilical port site. Patient ultimately underwent wide local excision of the full thickness abdominal wall mass at the umbilicus leaving a large abdominal wall defect, repaired with dual anterior and posterior compartment release with abdominal wall reconstruction with mesh.



Discussion

Gallbladder carcinoma, the most common carcinoma of the biliary tree, has proposed carcinogenic pathway of either dysplasia progressing to carcinoma in-situ and invasive carcinoma or the adenomatous polyp pathway. As patients with confirmed carcinoma have a 3% prevalence of adenomatous remnants compared to the 80% prevalence of dysplasia, the latter pathway is thought to be of greater clinical significance[2]. Though it is common to detect areas of dysplasia in specimens with confirmed carcinoma, it is far less common to discover foci of invasive carcinoma in gallbladder specimens incidentally found to have dysplasia. This raises the question of possible management and surveillance of this patient group moving forward after detection.



Further analysis of additional cross-sections of gallbladder upon detection to look for missed invasive carcinoma has been proposed and has shown to be unproductive[3]. Knowledge of the dysplasia to carcinoma timeline is purely deductive as progression of this epithelial lesion cannot be followed after gallbladder removal. Thus, an inadequate basis for reliable surveillance recommendations for detection of concomitant pancreaticobiliary lesions remains.

Conclusion

Detection of dysplasia without associated invasive carcinoma after routine cholecystectomy is a rare finding but not one completely without clinical significance. Further database analysis will help determine the appropriate surveillance.

References/Disclosures

The authors above have no disclosures

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