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LETTERS

Selective histopathology in cholecystectomy for gallstone disease

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We thank Drs Behari and Kapoor for the reference to our article [1], in their editorial [2].

Our article intended to highlight that while routine histopathology is the norm for gallbladder specimens, there may be cases where this may be omitted. We feel it may be omitted when every suspicion of gallbladder malignancy has been ruled out, such as a thickened gallbladder, ulceration, nodularity, polypoidal projections or other imaging features of the same (essentially a thin walled, macroscopically normal gallbladder). If one has any suspicion of malignancy, it is advisable to err on the side of sending the specimen for histopathology.

We agree that changes of acute inflammation, especially empyema, and thick fibrotic walls in chronic inflammation make it difficult or impossible to diagnose gallbladder cancer on macroscopic examination. This is aptly illustrated in a study where the two gallbladders with carcinoma were indistinguishable from 58 other thick walled gallbladders [3]. It is because of this difficulty that we recommend histopathology for all cases where the gallbladder wall is thickened.

We agree that the incidence of gallbladder cancer is high in Mirrizi's Syndrome and xanthogranulomatous cholecystitis. We reiterate that these cases are not suitable for selectively histopathology. We also agree that recommendations for routine histology of gallbladder specimens should take into consideration local incidence rates of gallbladder cancer. Therefore the policy of selective histopathology needs further study in areas of high incidence of gallbladder cancer, which includes North India.

While it is not uncommon to see patients with advanced gallbladder carcinoma a few months after cholecystectomy for presumed gallstone disease, we believe that these are a result of failure by the treating physician to recognize gallbladder cancer pre, intra and post operatively, and sometimes even on histopathology. In fact six out of the 11 patients with missed gallbladder cancer in the series by the editorialist were reported to have a normal histopathology [4]. This highlights the need for a high index of suspicion to diagnose gallbladder cancer.

We agree that if gallbladder carcinoma is suspected intra-operatively, the gallbladder should be subjected to a frozen section examination and if it is positive, an extended cholecystectomy should be performed if local expertise is available.

Selective histopathology of gallbladder specimens should therefore be applied only to a select subgroup of patients with gallstone disease.

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References

1. Mittal R, Jesudason MR, Nayak S. Selective histopathology in cholecystectomy for gallstone disease. Indian J Gastroenterol. 2010;29:26–30.
2. Behari A, Kapoor VK. Does gallbladder cancer divide India? Indian J Gastroenterol. 2010;29:3–7.
3. Srikanth G, Kumar A, Khare R, et al. Should laparoscopic cholecystectomy be performed in patients with thick-walled gallbladder? J Hepatobiliary Pancreat Surg. 2004;11:40–4.
4. Sharma A, Behari A, Sikora SS, Kumar A, Saxena R, Kapoor VK. Post-cholecystectomy biliary strictures: not always benign. J Gastroenterol Hepatol. 2008;23:e63–6.