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CASE STUDY

THE GALL-BLADDER TUMOR: ABOUT ONE CASE DIAGNOSED AT BANGUI FRIEND SHIP HOSPITAL.CENTRAL AFRICAN REPUBLIC

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ABSTRACT

The authors present one case of gall-bladder tumor diagnosed after laparotomy. The pathology analysis has given the diagnosis of gall-bladder primitive carcinoma. For this case, according to literature review, the authors present the diagnostic and therapeutic problems.so that they recommend the treatment of any diagnosed cholelithiasis as prophylaxis of gall-bladder carcinoma.

INTRODUCTION

Gallbladder cancers are rare, found in 2.2 to 0.4% of autopsies (Moreaux, 1979; Muir and Mori, 1986). It is found at an average frequency of 0.3-3.8% of surgical procedures on the biliary tract. This is a serious cancer has a poor prognosis, 5% 5-year survival (Henry *et al.,* 1977; Pelletier *et al.,* 1982). Despite the development of new medical imaging techniques, diagnosis of gallbladder cancer is still very difficult in a precarious situation because of infrastructure problems. In these cases, laparotomy and pathological examination of the specimen used to confirm the diagnosis of gallbladder cancer. We report the case of the first case of tumor of the gallbladder diagnosed at Friendship Hospital of Bangui. The objective of this study was to report the difficulties encountered on the diagnosis and treatment plan presence of this group of tumors discovered incidentally during laparotomy.

Observation

Mr. David H., 70 year old man is received surgical consultation September 7, 2012 for abdominal pain, belching, persistent dyspnea and tachypnea type of occupant presence of abdominal mass in the region of the right iliac fossa and iliac.

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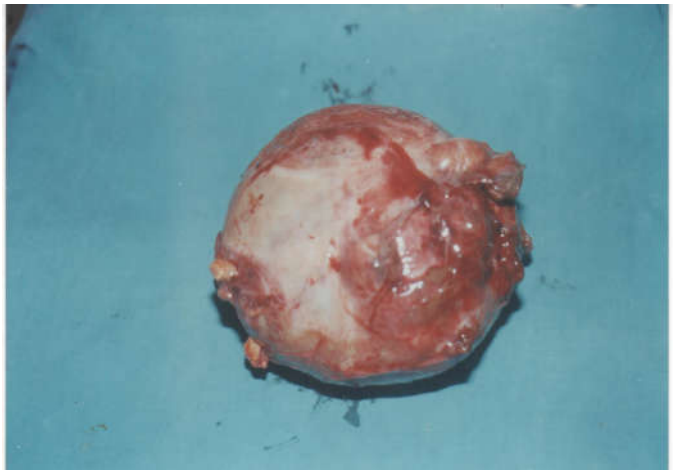
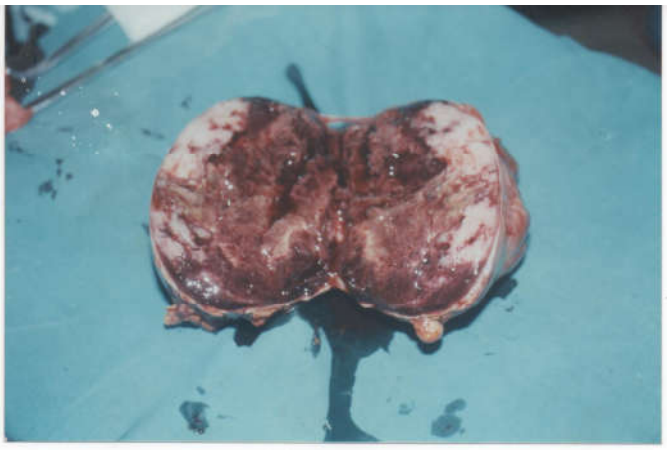
Ultrasound performed at the waning of that objective consulting a heterogeneous mass of the right iliac fossa, suggestive of malignancy coeccum probably associated with benign prostatic hyperplasia. Outside an unquantified smoking, the pay has no particular history on physical examination, the physical constants are normal; the overall condition is quite good. The abdominal palpation found a large tumor, the size of a grapefruit and movable in the hypogastrium. This tumor is firm and painless. The examination of other organs not found specific abnormalities. Admitted to the general surgery department, requested laboratory tests relate urea which is 053 g / l, glucose 0.51 g / l, hematocrit 24%, white blood cells to 4000 / mm3. The liver test was not performed as well as the balance of hemostasis. Tumor markers such as carcinoembryonic antigen and alpha feto-protein were available. The diagnosis is not clear, so that an exploratory laparotomy was performed September 9, 2012. The procedure is performed under general anesthesia with orotracheal intubation. This is middle astride the umbilicus enlarged on demand to the xiphoid. In exploration, we found a large tumor-appended to the bottom of the right liver. His height is about 15 cm in diameter consistency is rénitente Tumor adheres to the transverse colon and the anterior inferior surface of the stomach. The liver is full of color multiples nodulas that bleeding on contact. After release adhesions, we find that the cystic duct is dilated, the diameter of up to 5 cm, obstructed by the tumor in his neck. There is no deep lymphadenopathy. The



Picture 1. Gallbladder tumor aspect



Picture 2. macroscopic aspect of the gall bladder tumor

clinical diagnosis of a malignant tumor of the gallbladder is mentioned. The removal of the tumor is easy as an ideal cholecystectomy. In the tumor bed, there is a hemorrhagic suffusion. The fabric is very friable forces us to make a "packing" at the bottom of the right liver with 4 abdominal pads. The abdominal wall is closed in a plane and the removal of the "packing" contemplated in 48 hours. During surgery, the patient receives a transfusion of 2 pouches (500 ml) of whole blood Secure O positive. Admitted to the surgical intensive care unit, the patient dies to 19h30mn. The constant raised permit the conclusion to hypovolemic shock: blood pressure to 90/70 mm Hg, pulse 104 / min. The pathological examination carried out a posteriori confirms a primitive gallbladder adenocarcinoma had invaded all the parietal planes, liver cirrhosis.

Comment

The gallbladder cancer was described for the first time in 1777 (Lazcano-Ponce *et al.,* 2015). This cancer is characterized by its rarity and late diagnosis. In the literature, this cancer accounts for 85% of cancers of the bile ducts and less than 1% of all cancers (Ridha *et al.,* 2005). In our midst this cancer is rarely diagnosed. This first case was discovered incidentally during a laparotomy done for abdominal tumor occupying the upper qua drant and hypogastric. A systematic pathological examination cholecystectomy parts should confirm or deny this rarity of gallbladder cancer in Bangui as some authors think that gallbladder cancer is often associated with the stones in the gallbladder (Ridha *et al.,* 2005). This factor was also found in the European series where the association between gallstone and gallbladder cancer represents 70% of cases (Henry *et al.,* 1977; Takongmo *et al.,* 1989). For the Swiss League against Cancer, chronic inflammation of the gallbladder, usually accompanied by the presence of stones for many years is likely to be a risk factor. Contrary to what was thought a few years ago, the mere presence of calculations is not enough to increase the risk of cancer. By cons, people carrying salmonella (Salmonella typhi) asymptomatic as they have a risk of developing cancer of the gall bladder (Pierrick Horde, 2014). Clinically, malignant tumors of the gallbladder usually does not cause symptoms until the neighboring organs are affected. In advanced stages, gallbladder remains painless while forming a palpable induration in the upper abdomen. Palpation of a mass in the right upper quadrant is seen in 30-50% of cases especially in cases of acute cholecystitis (Ridha *et al.,* 2005). If the bile ducts are blocked by the tumor, reflux of bile into the liver causing jaundice (jaundice) that progresses rapidly. Other symptoms of gallbladder cancer are loss of weight and appetite, nausea and vomiting. Abdominal ultrasound is evokes the diagnosis in 88% of cases when the tumor is symptomatic. The search for tumor markers in the diagnosis of cancer of the gallbladder (CA (Cancer Antigen 19.9 ACE) have shown no interest in this type of cancer (Ridha *et al.,* 2005). In the pathological level, gallbladder cancer is characterized by the wide variety of macroscopic and histological aspects polymorphism. The typical macroscopic appearance is that of increased vesicle size, whitish, hard and adherent, invading the liver and forming a similar hépatovésiculaire tumor cases we diagnosed. In some atypical forms, the gallbladder is sclerosus or can take the appearance of a chronic cholecystitis (Ridha *et al.,* 2005) the diagnosis of gallbladder cancer then requires histological examination of all parts of cholecystectomy (Roa *et al.,* 1996). In 85 to 90% of cases it is variable differentiation adenocarcinomas. Despite the advent and development of modern diagnostic means, the gallbladder cancer is often diagnosed at a late stage, so no cure n 'is possible. However, radical surgery is the only potentially curative treatment of gallbladder cancers. Since the stones in the gallbladder are an etiological factor value, it is recommended as a preventive measure, the treatment of any stones in the gallbladder diagnosed (Takongmo *et al*., 1989).

Conclusion

The gallbladder cancer is a rare and serious condition. Given the problems related to means of investigation, diagnosis is often difficult in our environments often palliative treatment must be surgical. The improved prognosis can only be achieved through an identification of populations at risk, early diagnosis, treatment of precancerous lesions and reasonable surgical aggressiveness.

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