Case report

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PALLIATIVE ENDOSCOPIC TREATMENT OF METASTATIC COLORECTAL CARCINOMA IN GALLBLADDER TRACT

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Colon cancer produces intestinal metastases quite frequently. Metastatic changes of colon cancer seldom cause obstructive jaundice. Case report: A 77-year-old woman was admitted with clinical icterus and recidive cholangitis. Four years prior to the admittance she had been treated for adenocarcinoma of the sigmoid colon, a year after, due to liver metastases, left hepactectomy was performed. After two years, choledochotomy was done due to extrahepatic biliary obstruction and a biliary stent was implanted. Five months afterwards, purulent holangitis developed, so the stent was removed and choledoduodenoanastomosis was done. Owing to reoccurence of icterus as well as cholangitis, an endoscopic retrograde cholangiopancreotography was done and metastatic adenocarcinoma of gallbladder tract was diagnosed. Regarding the disease spreading, we chose palliative treatment by implanting endoscopic biliary endoprosthesis. Conclusion: In patients with icterus or cholangitis suffering from metastatic disease of colorectal carcinoma, one should consider several causes for obstruction and apply palliative cure by implanting endoscopic biliary endoprosthesis. *Acta Medica Medianae 2011;50(1) :44-46.*

Key words: *obstructive jaundice, colon, cancer, endoscopic retrograde cholangiopancreatography*

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Introduction

Colon cancer metastases more rarely cause obstructive jaundice, which occurs when located near the liver hilus and in case when they are big (1). Possible causes for obstructive jaundice occurring are the outer compression onto the gallbladder tract by portal limphoglandulae (2,3), infiltration through the gallbladder tract (4), intraluminal defects due to the mass of deposited detritus, tumor producing mucus (4,5), in extremely rare cases, by isolated metastases in the very gallbladder tract (6-9) and, in the rarest cases, by primary tumor of the gallbladder tract (1,10). However, one has to consider the other possible causes of obstructive jaundice such as concrements, sludge, blood clots, parasites and surgical residual parts.

Case study

A 77-year-old woman was hospitalized at our Institution and diagnosed with recurrent cholangitis. Here we deal with a patient who had been diagnosed with adenocarcinoma of sigmoid colon four years before the admittance, and had undergone a sugery. After a year, metastatic changes were diagnosed within the left lobe of the liver and hepatectomy was performed. Two years afterwards, choledochotomy was done due to extrahepatic biliary obstruction and a biliary stent was implanted. Five months after that, purulent hepatocholangitis developed and the stent was surgically removed and choledoduo-denoanastomosis was implanted. Upon hospital admittance, the patient was febrile, subicteric and painful under the right cage. The laboratory tests indicated leukocytosis, increased inflammation paremeters, overall bilirubin level of 50 nmol/l, direct bilirubin level of 37nmol/l and alcal phospha-tases of 1052. Transaminases were twice as high. Ultrasound abdominal examination showed dilatory intrahepatic gallbladder tracts and secondary liver deposits, which was confirmed by abdominal CT scan. Endoscopic retrograde cholangiopancreato-graphy (ERCP) papila in situ was seen, while through choledohoduodenanastomosis detritus, microcalculi and pus were isolated. Administration

of infusion and parenteral antibiotics improved the clinical condition of the patient, so she was released from hospital. She was re-admitted after a month due to a re-occurence of cholangitis, and ERCP was re-done due to the „sump syndrome" and sphincterotomy was done followed by choledochal cleaning which basket-evacuated part of tissue for pathohistological analysis.

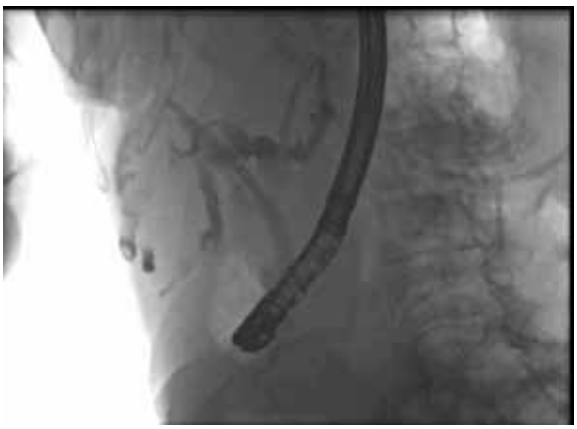

Figure 1. Re ERCP performed, stent exchanged No II (10 Fr,12&10cm)

Pathohistological finding showed metastatic colorectal adeno-carcinoma of choledochus, so it was decided to implant a biliary endoprosthesis through papilla (7Frx9cm) followed by repeated cleaning both through papilla and by choledoho-duodenoanastomosis. Two months after this procedure, cholangitis re-occured, so ERCP was repeated, the stent formerly placed evacuated and after cleaning two new stents were implanted of 10Fr 12 i 10cm, respectively (Figure 1). During hospitalization, due to infusion therapy, parenteral antibiotics as well as symptomatic and supportive therapy, the value of inflammatory markers normalized, so the patient was released from hospital and advised to have regular gastro-intestinal checkups. A year after her last ERCP, the patient died due to pneumonia in the right lung. The level of bilirubin was normal, which refers to gallbladder tract having patency, with the presence of the stents.

Discussion

In patients with metastatic colorectal carcinoma who develop obstructive icterus, one should by all means have in mind the possibility of metastases in the gallbladder tract itself. In order to diagnose this disorder, it is necessary to fulfill rigid criteria, which means: careful analysis of the history of the disease, careful examination of morphological state of choledochus tumor and a thorough comparison of histological choledochus tumor finding with the histological finding of the primary tumor (10). The diagnosis with a high level of probability can be done when ERCP findings are simultaneously compared with histological finding of the primary tumor of the colon (9). Resection has been the most successful method in treating obstructive jaundice so far. However, biliary endoprostheses, considering patients' age, co-morbidity and disease spreding, represent a way of palliative treatment of icterus or cholangitis. One should strive to implant more than one biliary endoprosthesis whenever possible. Mean survival in untreated patients with extrahepatic biliary obstruction by metastatic colorectal carcinoma is 0.6 month whereas the survival after biliary decompression can be as long as 42 months (11, 12).

Our patients lived 14 months after pathohistological finding of metastatic adenocarcinoma of the gallbladder tract, which indicates that endoscopic palliative treatment with biliary endoprostheses improve the quality of life and survival period.

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PALIJATIVNO ENDOSKOPSKO REŠAVANJE METASTATSKOG KOLOREKTALNOG KARCINOMA U ŽUČNIM VODOVIMA

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Karcinom debelog creva vrlo često stvara metastaze u jetri. Metastatske promene karcinoma debelog creva retko izazivaju opstruktivnu žuticu.

Žena stara 77 godina, primljena je pod kliničkom slikom ikterusa i recidivantnog holangitisa. Četiri godine pre prijema operisana je zbog adenokarcinoma sigmoidnog kolona, nakon godinu zbog metastaza u jetri učinjena je i leva hepatektomija. Nakon dve godine zbog pojave ekstrahepatalne bilijarne opstrukcije uradjena je holedohotomija i postavljen bilijarni stent. Za pet meseci dolazi do razvoja purulentnog holangitisa, te je stent uklonjen i uradjena holedohoduodenoanastomoza. Zbog ponovno nastalog ikterusa i holangitisa urađena je endoskopska retrogradna holangiopankreatografija i dijagnostikovan metastatski adenokarcinom žučnog voda. Obzirom na proširenost bolesti odlučili smo se za palijativno lečenje implantacijom endoskopske bilijarne endoproteze.

Kod pojave ikterusa ili holangitisa bolesnika sa metastatskom bolesti kolorektalnog karcinoma treba razmotriti više mogućnosti uzroka opstrukcije i primeniti moguće metode lečenja od kojih poseban značaj leži na endoskopskoj retrogradnoj holangiopankreatografiji. *Acta Medica Medianae 2011;50(1):44-46.*

***Ključne reči**: opstruktivna žutica, karcinom debelog creva, endoskopska retrogradna holangiopankreatografija*