

Fig. 1 Operative findings.

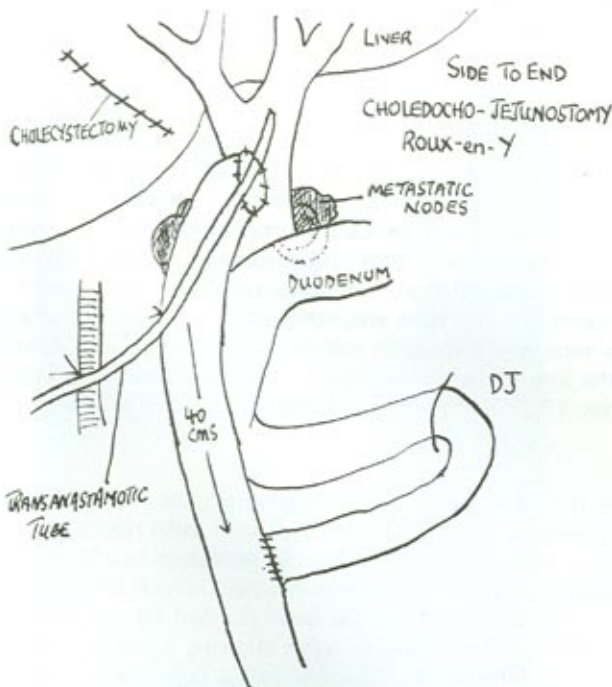


Fig. 2 Operative procedure done

**Discussion**

Prognosis of Carcinoma gallbladder is the poorest of all intra abdominal malignancies<sup>1</sup>. Usually a patient survives only a few months after the diagnosis. The only chance of effecting a long term cure for carcinoma gallbladder is when the lesion is in situ in which stage it cannot be diagnosed pre-operatively. The patients whose disease has been spread beyond the gallbladder have a better chance of survival with an extended operation involving excision of the surrounding liver, skeletonisation of the common bile duct and lymphadenectomy: the only 5 year survivals are in patients in whom extended surgery was undertaken<sup>2</sup>.

There have been isolated reports of surgeons removing the right quadrate lobe of liver for Carcinoma gallbladder since the early 60s'. This does not improve the outcome.

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## Obstructive Jaundice due to Pancreato-duodenal Lymph Node Metastases from Carcinoma Gallbladder

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### Abstract

Lymph node metastases from a carcinoma gallbladder is usually thought to be to the hilum of the liver but actually lymph node spread is to the pancreato-duodenal lymph nodes<sup>3,4</sup>. The fallacy is due to the fact that patients usually present late with jaundice, a large mass in the right hypochondrium and direct extension of the tumour to the hilum of the liver. The following is a case report of a patient with jaundice due to metastases to pancreato-duodenal lymph nodes from a carcinoma of the gallbladder.

**Key words:** Carcinoma gallbladder - obstructive jaundice - pancreato-duodenal lymph node.

### Case Report

A middle aged lady presented in July 1984 to Services Hospital, Lahore, with a hard non-tender mass in the right upper quadrant and jaundice of six weeks duration. Physical examination revealed obvious jaundice, a hard rounded palpable mass and a palpable liver one finger breadth below the costal margin. Her Hb was 10.2 gm/dl, bilirubin 11.3 mg/dl and alkaline phosphatase of 700 units/dl. Ultrasound examination showed a common bile duct (CBD) dilated to 1.8 cms. There were no calculi. The gallbladder, however, was distended and did contain calculi but was not obstructed. The wall of the fundus of gallbladder was thickened. She was put on vitamin K, high dextrose intake and a broad spectrum antibiotic.

3 days after admission she was initially explored through a right upper paramedian incision. A growth in the fundus of the gallbladder measuring 4.0 cms x 3.5 cms was noted. The liver was not involved. A biopsy was taken from the growth and the abdomen was closed.

She was referred to our unit and re-explored one week later. At laparotomy, her liver was free of metastases, there was no ascites. The head of pancreas was within normal limits, there were no peritoneal seedlings, the lower end of the common bile duct was obstructed by a group of hard lymph nodes behind the duodenum (Fig. 1) leading to dilation of the CBD. A cholecystectomy and choledocho-jejunostomy, Roux-en-Y was done, side to end with a proximal limb of 40 cms, and a transanastomotic latex tube exiting through jejunal loop to the exterior. Her post-operative course was uneventful. Her tube was removed on the day 10 after a tube cholangiogram which showed good flow down the jejunum with no leakage. She was discharged on the day 13 with a biopsy confirming carcinoma gallbladder.

In the 18 months following operation, she has not been jaundiced, but has had bouts of fever with rigors which have settled with antibiotics. She has been having severe abdominal pain radiating to her back which has restricted her socially. She has been scanned by ultrasound twice at six monthly intervals showing a normal intra-hepatic biliary tree. She has had a poor appetite and has been steadily losing weight having lost 28 lbs over the last 18 months.

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