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Case Report

Gall Bladder Polyps- Cholecystectomy Not For All.

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Abstract

Introduction: Incidental gallbladder polyps (also known as polypoid lesions of the gallbladder) are a common sonographic finding, occurring in approximately 3%–6% of the general population. Although most are benign cholesterol polyps (also known as cholesterol pseudo polyps) or inflammatory polyps, a small percentage of them are true neoplastic polyps, which have an unknown though small malignant potential.

Case Report: We report a fifty-year-old male, not a known case of any chronic illness, non-smoker, non-alcoholic, presented with non- ulcer dyspepsia symptoms and constipation for last two months. There was no history of haematemesis, malena, fever, weight loss, jaundice. All his routine labs were normal and ultrasonogram abdomen showed two small gall bladder polyps of 3mm which were differentiated from gall bladder stones on basis of absence of post-acoustic shadow and stable position, even on changing position. He was advised laparoscopic cholecystectomy by some surgeon in private hospital. At this point of time, he came for opinion to our department. On detailed evaluation of his clinical history, examination and investigations, it was decided that there was no need of laparoscopic cholecystectomy and he was put on proton pump inhibitors (PPI), Prokinetics, laxatives and dietary advise of decrease intake of spicy, sugary and oily foods and increase intake of water, fruits, salads and roughage in the diet. He became asymptomatic within one month and thus dosages were decreased and ultimately were stopped after three months. On follow up after six months, he is symptom free that too without any medications but dietary advices are being continued. His repeat ultrasonogram showed same size of both the gall bladder polyps. He has been suggested six monthly ultrasonogram and review.

Conclusion: Gall bladder polyps are commonly diagnosed on ultrasonogram and decision of cholecystectomy should be taken on scientific rationale and recommendations. Every surgical procedure has its own inherent risks and should be done where it is clearly indicated.

Keywords: Gall bladder Polyp, Ultrasonogram, Computed tomography scan, Endoscopic ultrasonogram, Cholecystectomy.

INTRODUCTION

Incidental gallbladder polyps (also known as polypoid lesions of the gallbladder) are a common sonographic finding, occurring in approximately 3%–6% of the general population (1,2). Although most are benign cholesterol polyps (also known as cholesterol pseudo polyps) or inflammatory polyps, a small percentage of them are true neoplastic polyps, which have an unknown though small malignant potential. The majority of sonographically identified gallbladder polyps (GP) are nonneoplastic, most commonly benign cholesterol polyps or inflammatory-type polyps. Non- neoplastic polyps are usually smaller than 10 mm in diameter with negligible, if any, risk of developing dysplasia or malignancy. Approximately 0.4% of patients undergoing cholecystectomy are found to have neoplastic polyps. Also, age is an important factor, as the prevalence of polyps increases with age, reaching its peak in people aged 40-50 and decreasing after 60 (3). Well-known risk factors for GP development and progression include male sex, age, dyslipidaemia, and non-alcoholic fatty liver disease (3). Some risk factors associated with the malignancy of vesicular polyps include the size (greater than10 mm), advanced age, and the presence of gallstones (4). Regarding the size of polyps, some authors have found that polyps >10 mm have a higher risk of malignancy, but they have also found reports of malignancy in polyps <10mm, therefore have established the cut with an appropriate sensitivity and specificity for polyps >6 mm in diameter (5). Although abdominal ultrasound is the first-line study for the detection of this type of lesion (due to its low cost, easy availability, and high diagnostic sensitivity) new advances in modern endoscopy have allowed endoscopic ultrasonography (EU) to optimize the diagnosis and characterization of neoplastic polyps, to provide a better therapeutic approach (6).

Case Report- We report a fifty-year-old male, not a known case of any chronic illness, non-smoker, non-alcoholic, presented with non- ulcer dyspepsia symptoms and constipation for last two months. There was no history of haematemesis, malena,

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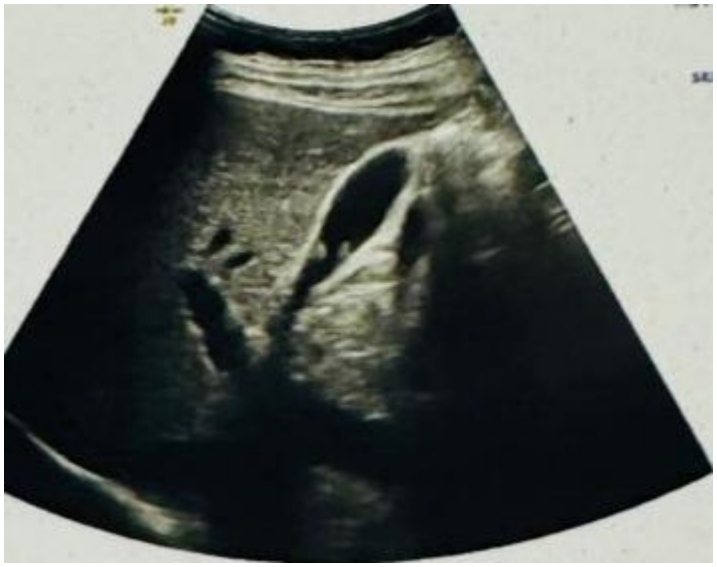
fever, weight loss, jaundice. The clinical examination including generalized physical and systemic of chest, cardiovascular, per abdominal and neurological was essentially normal All his routine labs including complete hemogram, liver & renal function tests, thyroid profile, blood sugar, serum electrolytes, ECG, Chest X-ray, urine complete examination, HbsAg, anti HCV & anti-HIV antibody were negative. The ultrasonogram abdomen showed two small gall bladder polyps of 3mm which were differentiated from gall bladder stones on basis of absence of post-acoustic shadow and stable position, even on changing position. He was advised laparoscopic cholecystectomy by some surgeon in private hospital. At this point of time, he came for opinion to our department. On detailed evaluation of his clinical history, examination and investigations, it was decided that there was no need of laparoscopic cholecystectomy and he was put on proton pump inhibitors (PPI), Prokinetics, laxatives and dietary advise of decrease intake of spicy, sugary and oily foods and increase intake of water, fruits, salads and roughage in the diet. He became asymptomatic within one month and thus dosages were decreased and ultimately were stopped after three months. On follow up after six months, he is symptom free that too without any medications but dietary advices are being continued. His repeat ultrasonogram showed same size of both the gall bladder polyps. He has been suggested six monthly ultrasonogram and review.

Figure 1. Two Small Gall Bladder Polyps Attached On Gall Bladder Wall.



CONCLUSION

Gall bladder polyps are commonly diagnosed on ultrasonogram and decision of cholecystectomy should be taken on scientific rationale and recommendations. Every surgical procedure has its own inherent risks and should be done where it is clearly indicated.

Conflict of Interest

The authors declare that there was no conflict of interest and no funding was taken from any source to conduct this research. The consent was taken from the patient and family members before publication of this paper.

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