

Gallbladder Polyps: An Ambiguous Cause of Biliary Colic

Sir,

The incidence of asymptomatic gallbladder polyps is steadily rising. This is probably due to the overzealous use of or availability of better-resolution ultrasonography. Patients commonly present with dull-aching pain in the right hypochondriac region and rarely with a biliary colic.^[1] In this paper, we present a less common clinical scenario.

A 49-year-old female patient presented to us with pain in the right hypochondriac region since 2 h (biliary colic). She denied history of fever, jaundice and clay colored stools and never had similar pain in the past and had family (mother) history of gallbladder cancer. She neither had any medical comorbidities such as diabetes mellitus, hypertension, chronic obstructive pulmonary disease and ischemic heart disease nor did she undergo any surgery in the past. On examination, she had body mass index of 32 kg/m². Her general and per-abdominal examinations revealed no abnormalities. Her hematological investigations revealed a marginally raised alkaline phosphatase and other investigations were within the normal limits. At that moment, our clinical impression was of biliary colic. However, ultrasonography revealed multiple hyperechoic mass lesions protruding in the gallbladder lumen suggestive of gallbladder polyps [Figure 1], largest one measured 8.2 mm [Figure 2]. Subsequently, the patient underwent conventional 4-port laparoscopic cholecystectomy. Histopathology revealed the benign nature of the pathology.

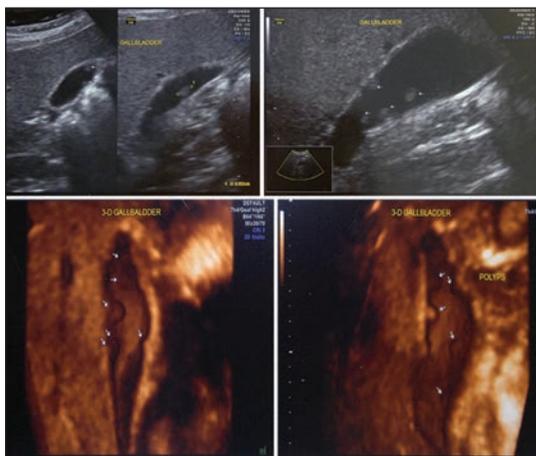


Figure 1: Ultrasonography depicting gallbladder polyps. Note the size and number

Clinically, polyps usually are asymptomatic and are more commonly detected incidentally. However, they may present with dull aching right hypochondriac pain, nausea and dyspepsia.^[1] Persley advocated that in the absence of other findings, the gallbladder polyp may be considered to be a source of biliary colic^[2] (once detached they may behave like a gall-stone). The present-day classification describes polyps into neoplastic and non-neoplastic groups.^[1,2] The non-neoplastic polyps, which are more common, may present as single large or multiple small (less common) varieties. Cholesterol polyps are the most common variety. Polyp associated with adenomyomatosis (benign hyperplastic proliferation of surface epithelium) is usually single and commonly seen at fundus. However, its association with multiple polyps is not clearly described.^[1] With increasing use of ultrasonography, the detection rates of polyps have increased. On ultrasonography, they appear as fixed hyperechoic mass lesion projecting in the gallbladder lumen with or without an acoustic shadow.^[3] Even though, the first-line investigation of choice, ultrasonography is considered less sensitive in diagnosing polyps less than 1 cm diameter.^[4]

Once diagnosed on ultrasonography, the first question born in patient's mind is—"is it malignant?" Replace with the below. In that context, the proposed criteria that point towards the malignant nature of the polyp have been: The age of patient (>50 years), the size of the polyp (>1cm diameter) and the coexisting gallstone.^[5] However, the relationship between the number of polyps and the risk of developing malignancy remains hazy even today. Symptomatic gallbladder polyps require cholecystectomy; but the controversy comes when they are detected incidentally. The current literature accepts the cut-off of 6 mm (10 mm with older) diameter to plan surgical extirpation of the gallbladder, and those less than 6 mm diameter require serial monitoring (6 monthly serial imaging).^[5]

However, especially in developing nations, we feel that, the surgeon should also take the account of the patients'



Figure 2: Cut-open specimen of gallbladder (strawberry) showing multiple (pediculated) polyps

educational background, compliance and their accessibility to the nearby hospital in case any need for cholecystectomy arises in future. Thus, till the time some robust data makes its way to the present-day literature, the anatomical, clinical as well as socio-economic factors should be considered and frankly discussed with the patient before making any decision in favor of (or against) operative intervention.

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