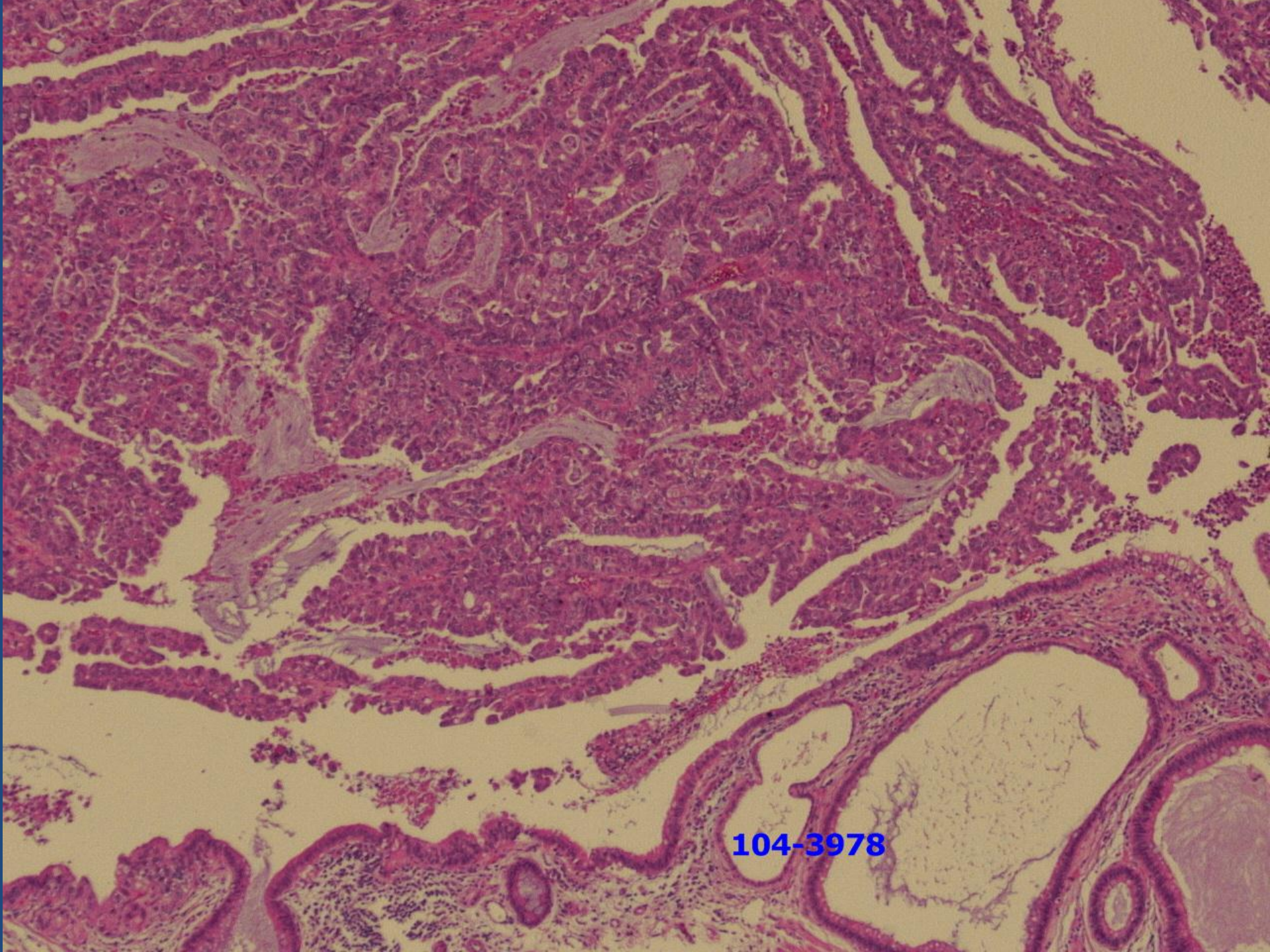
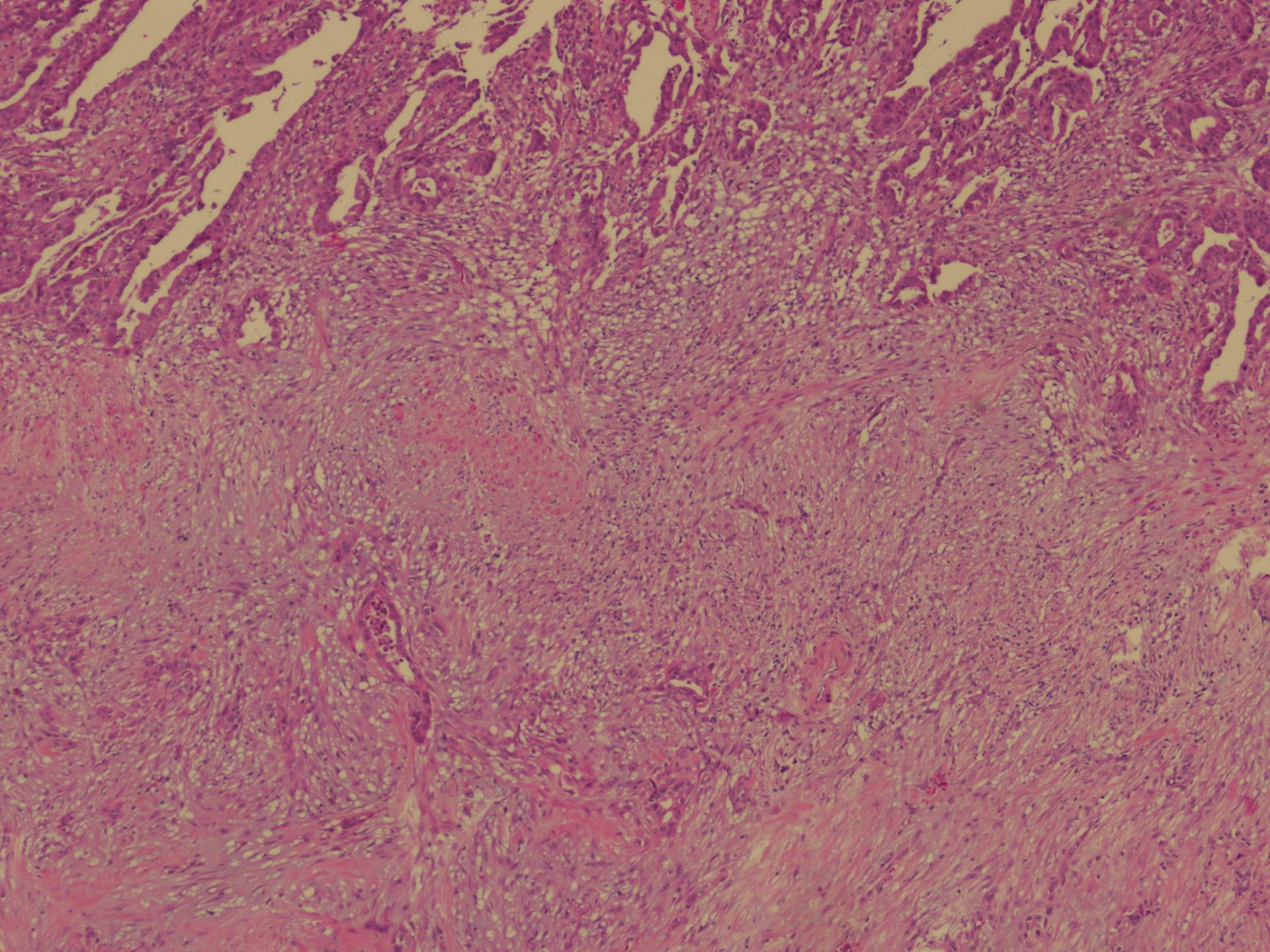


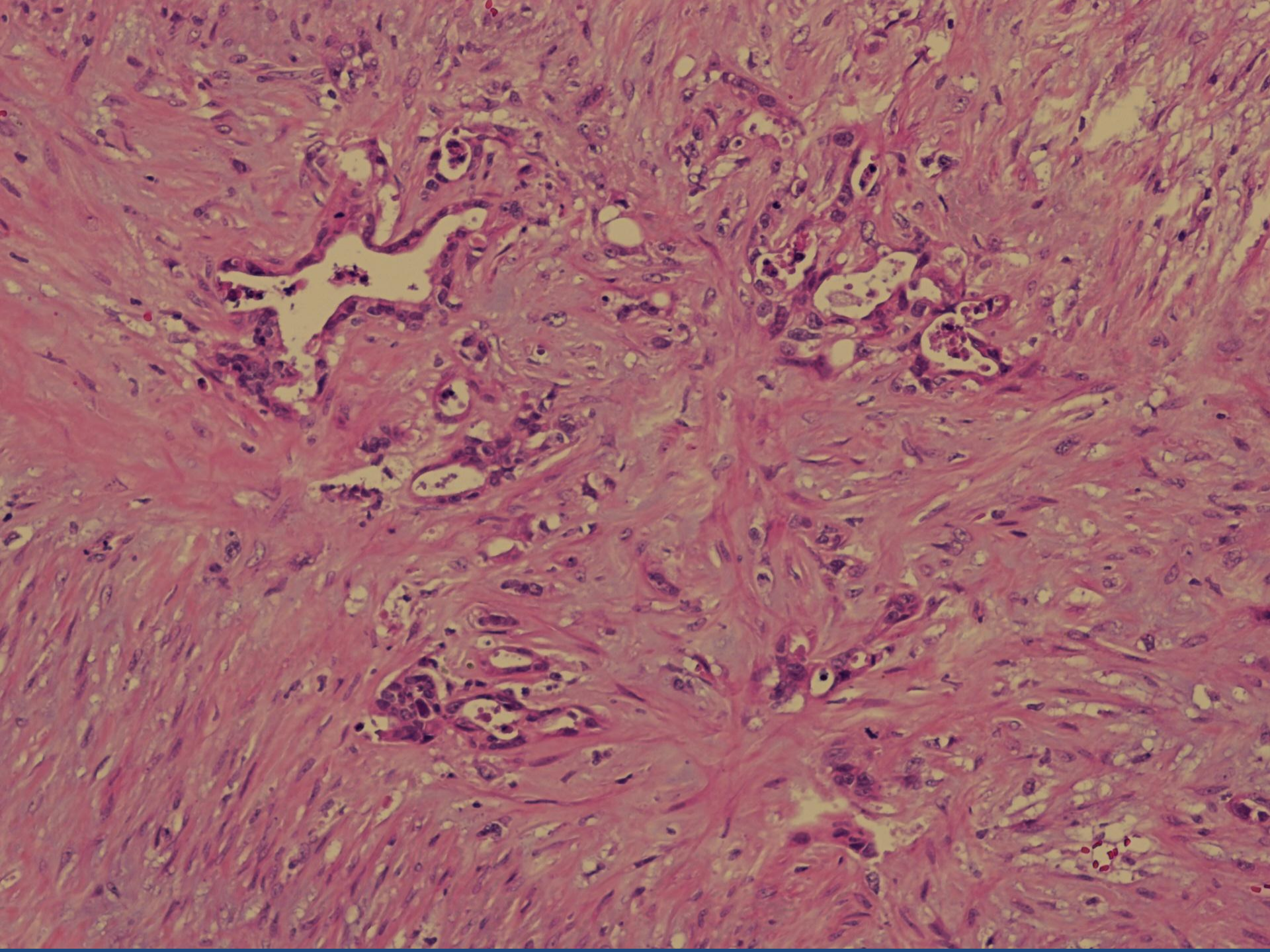
XXX-XXXX

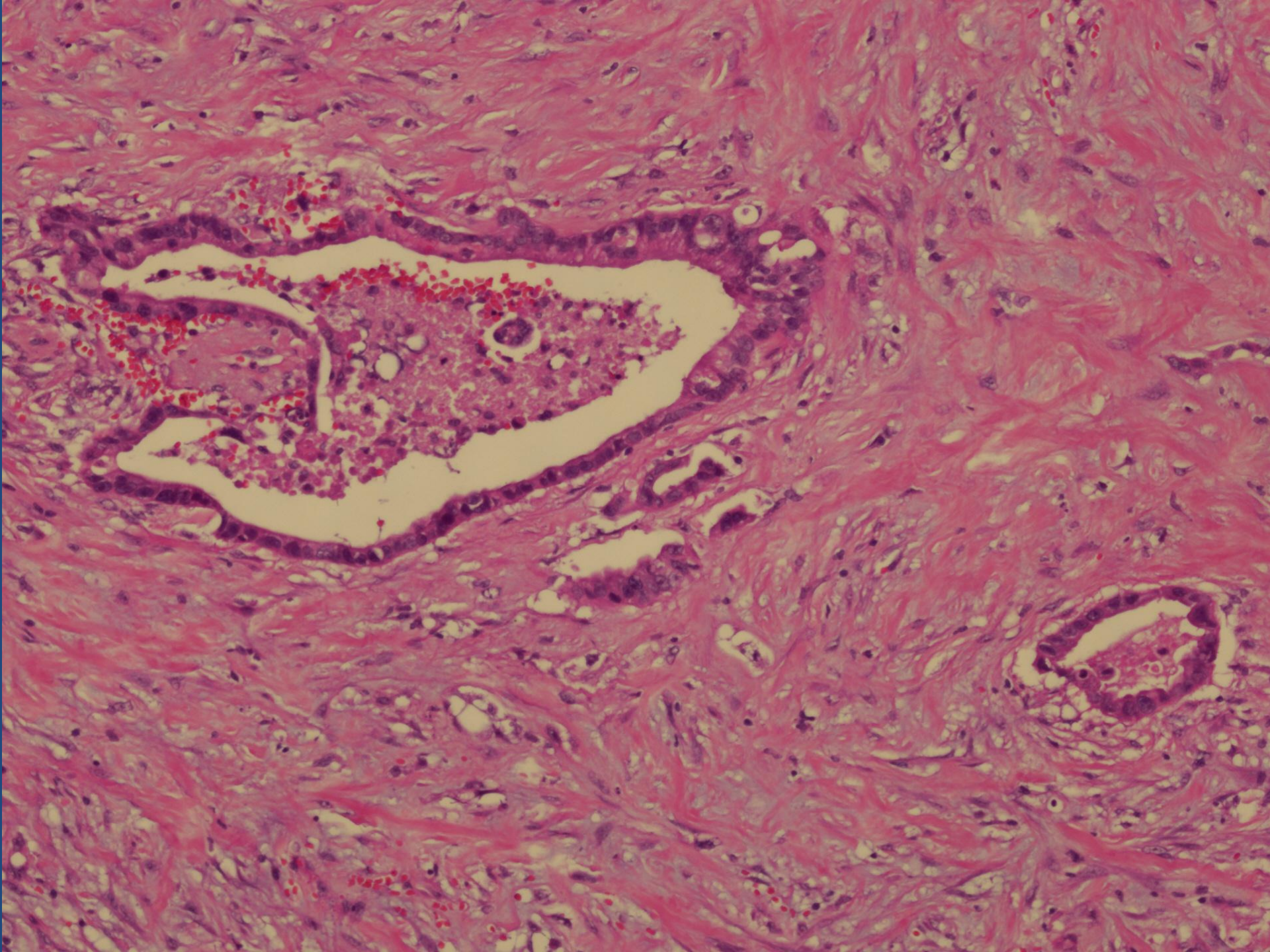
病理科李鯨瀛醫師

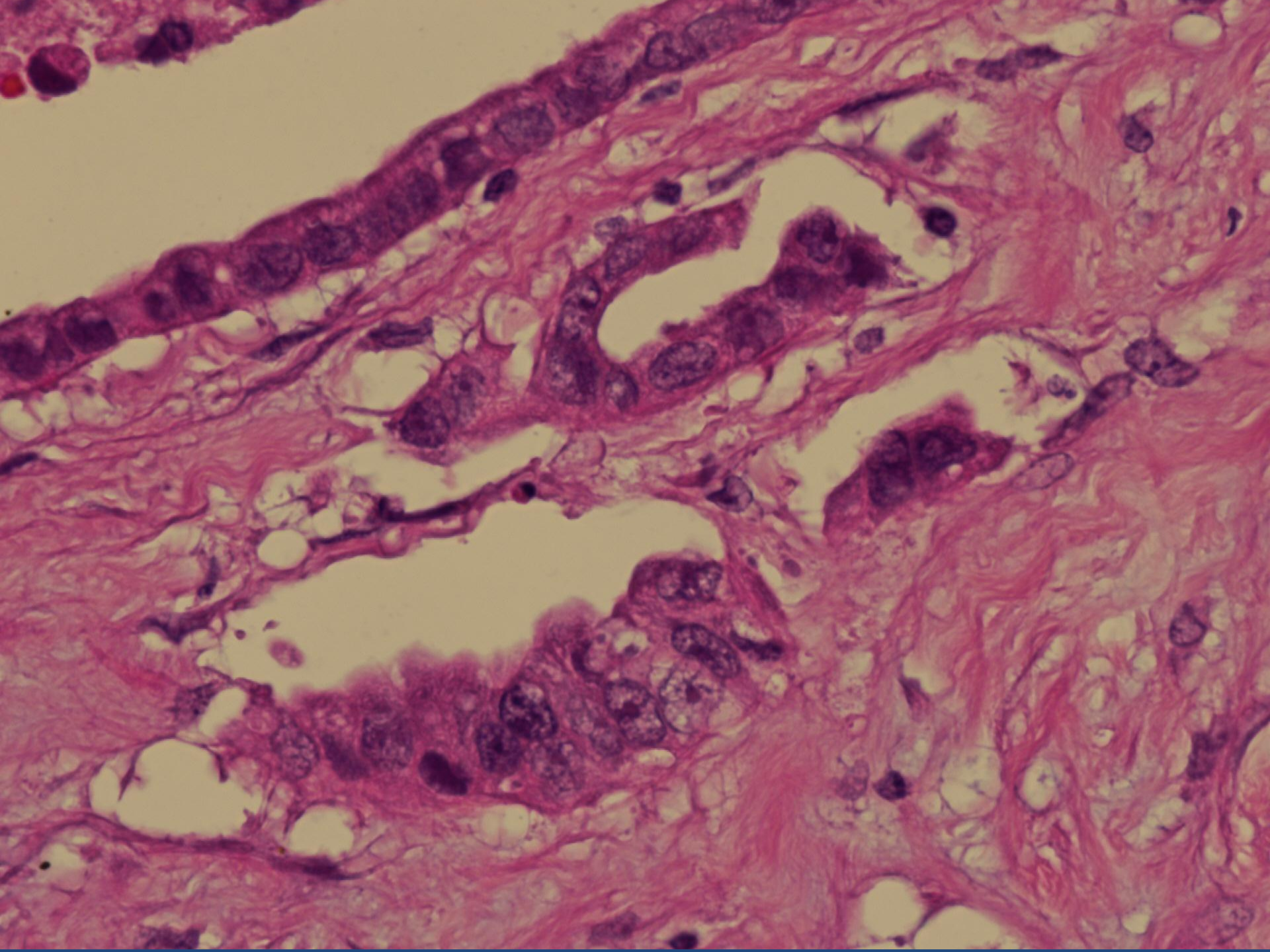


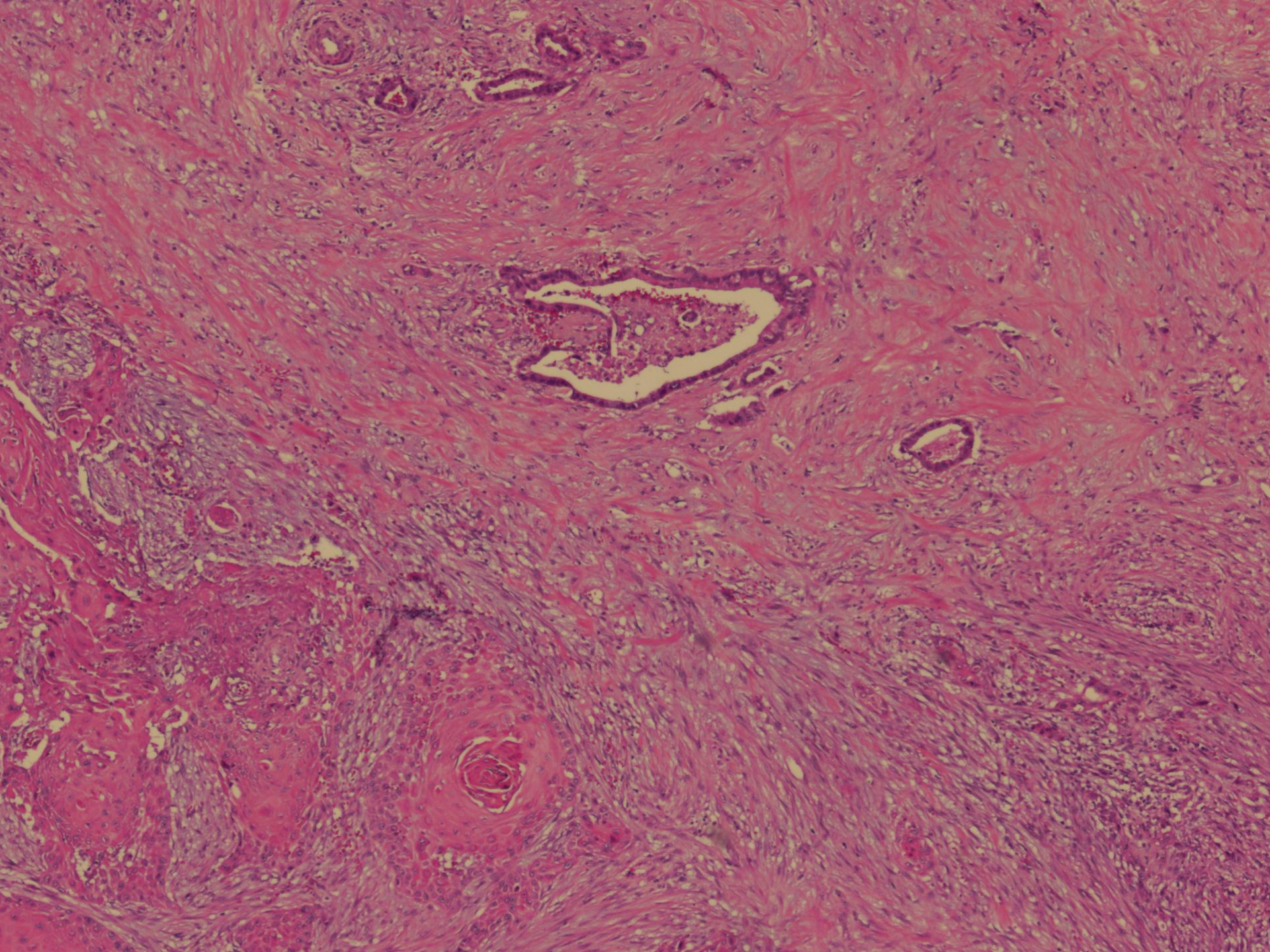
104-3978

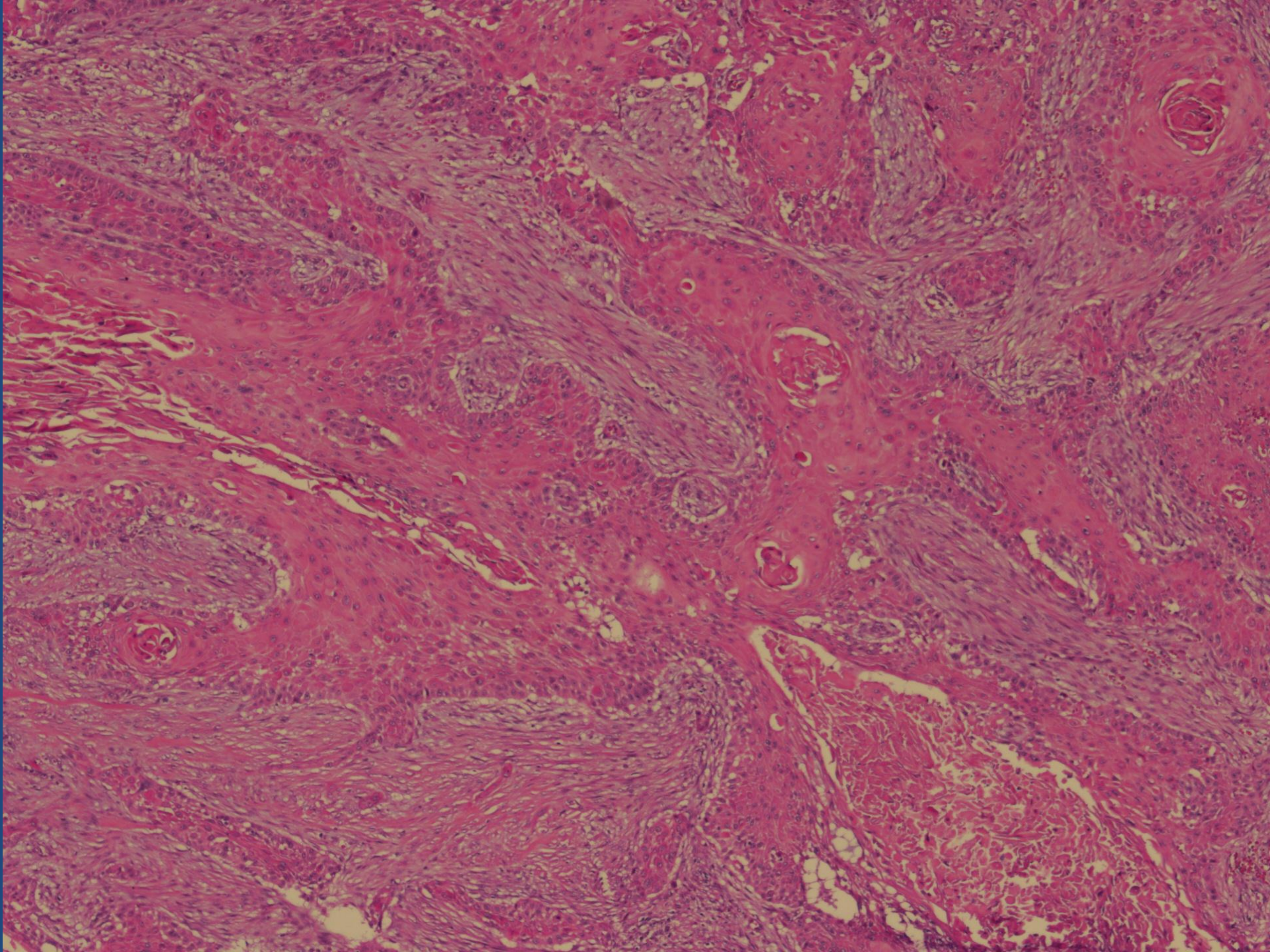




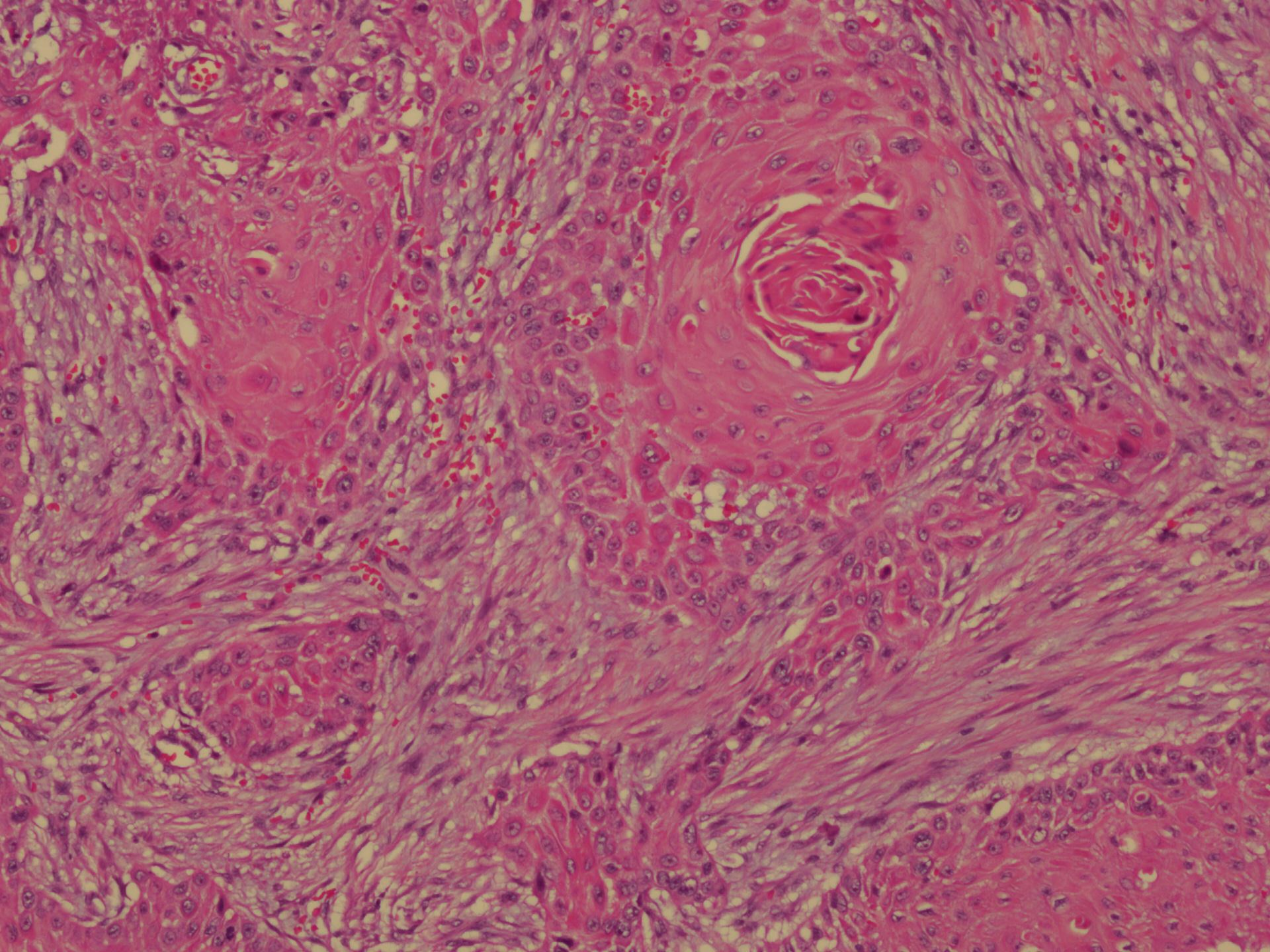


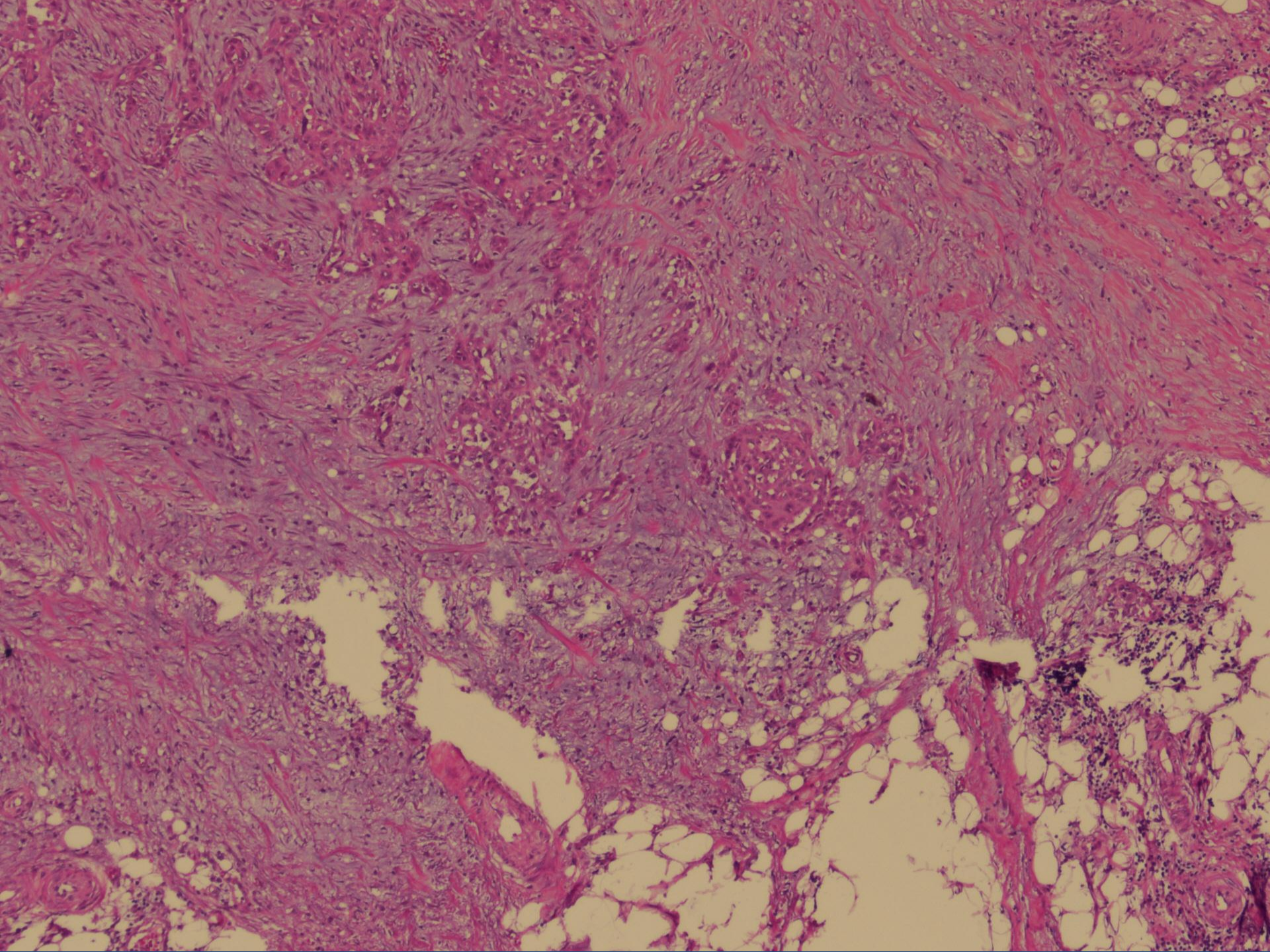


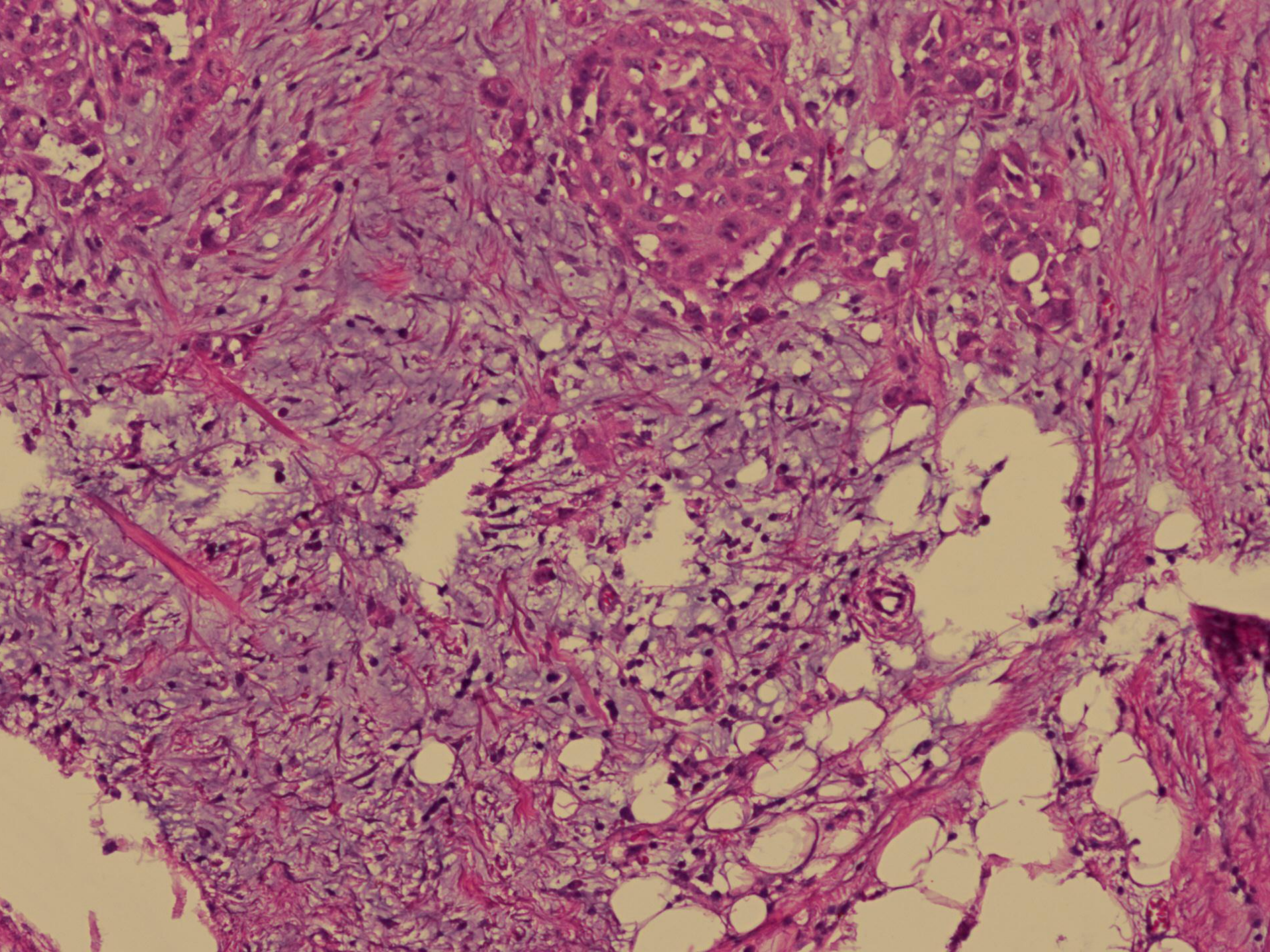


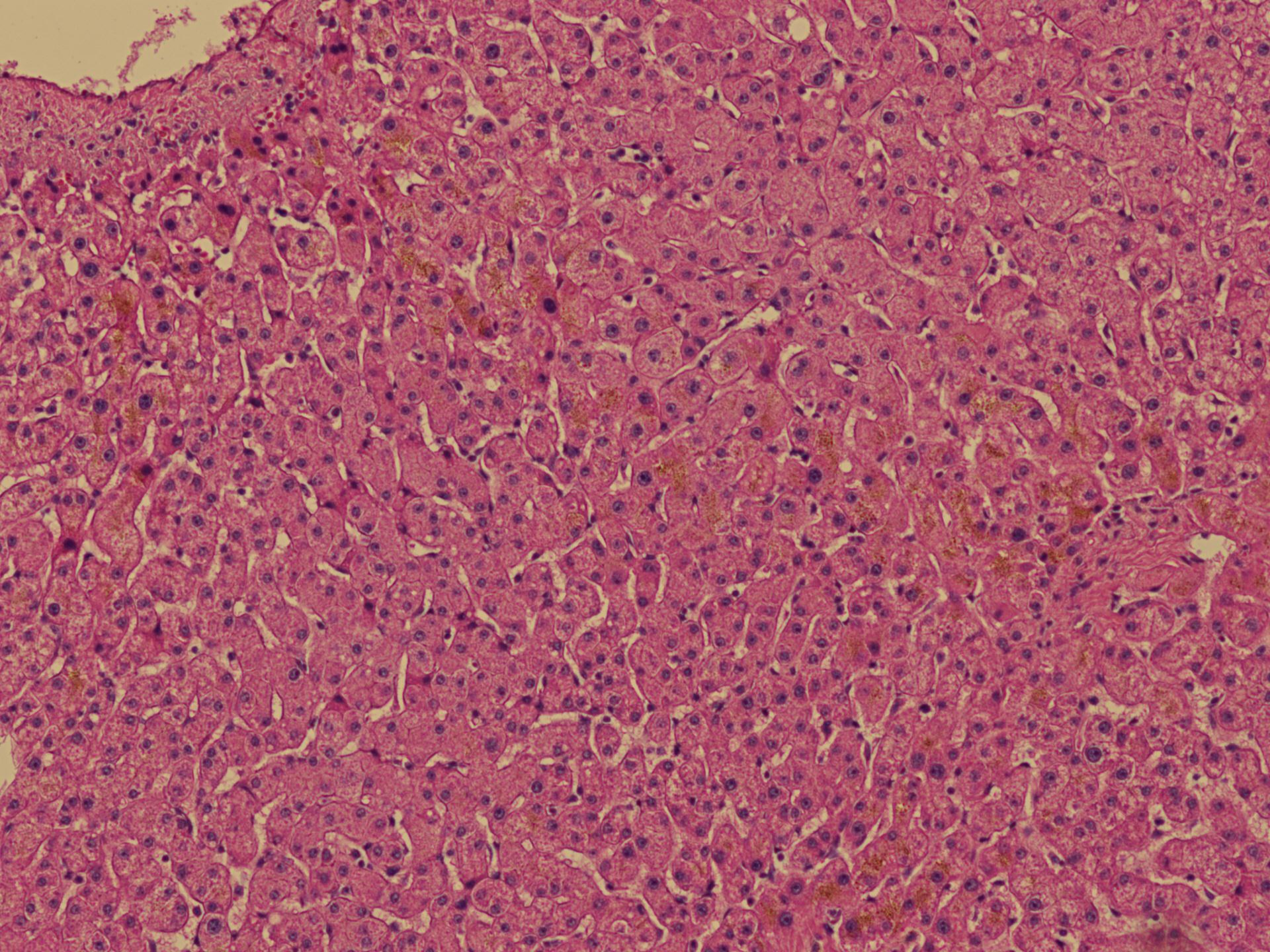


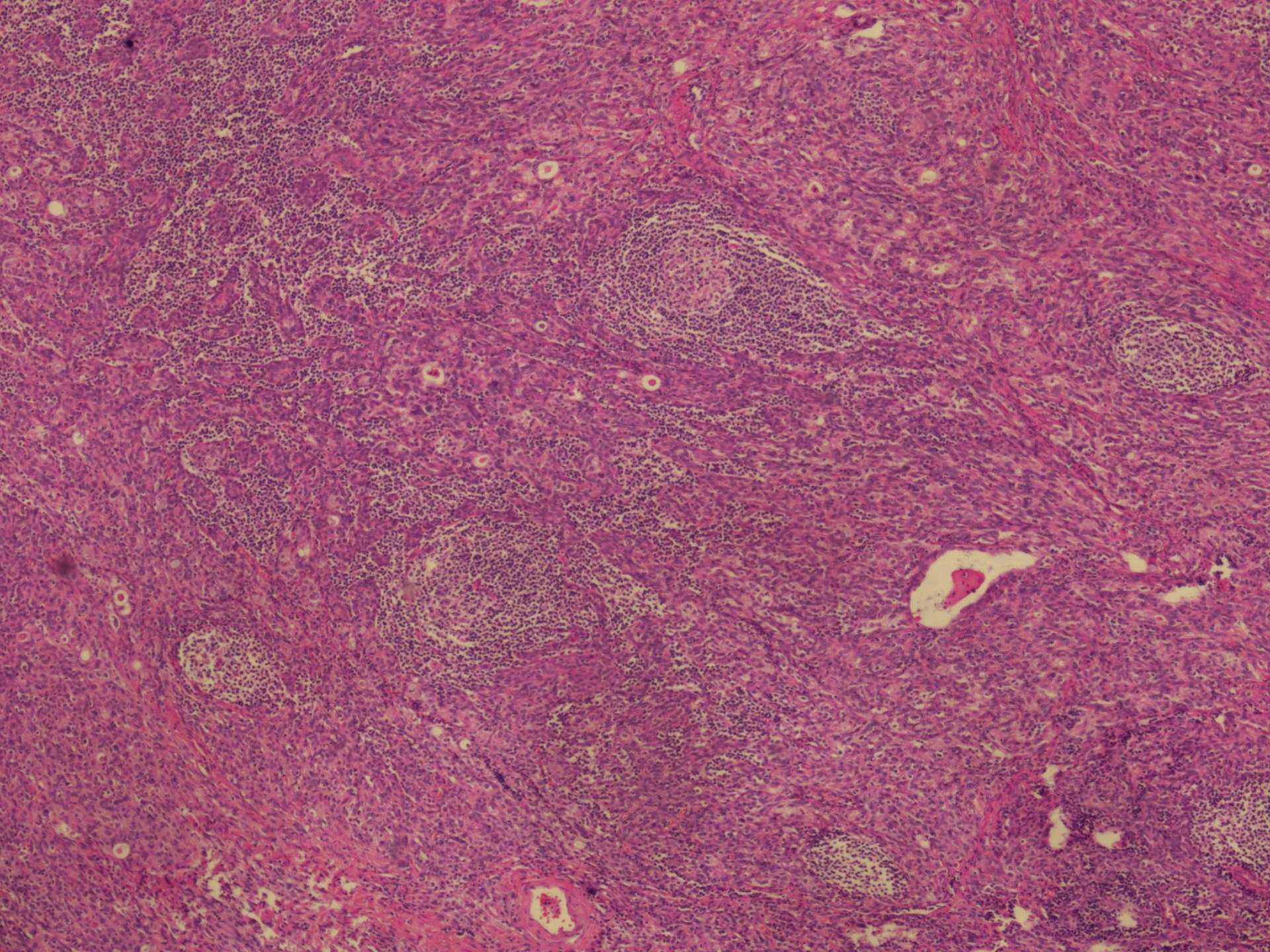


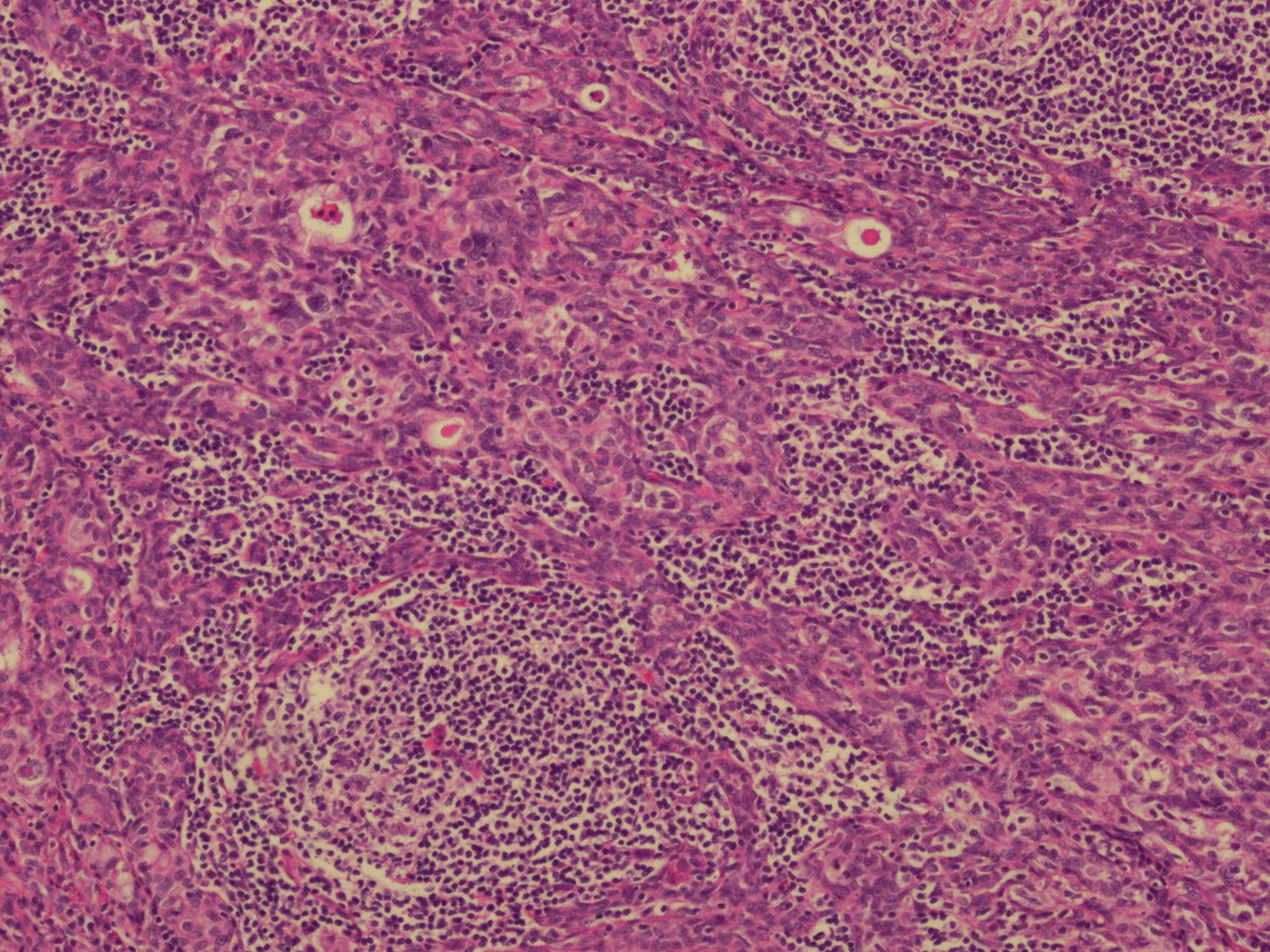


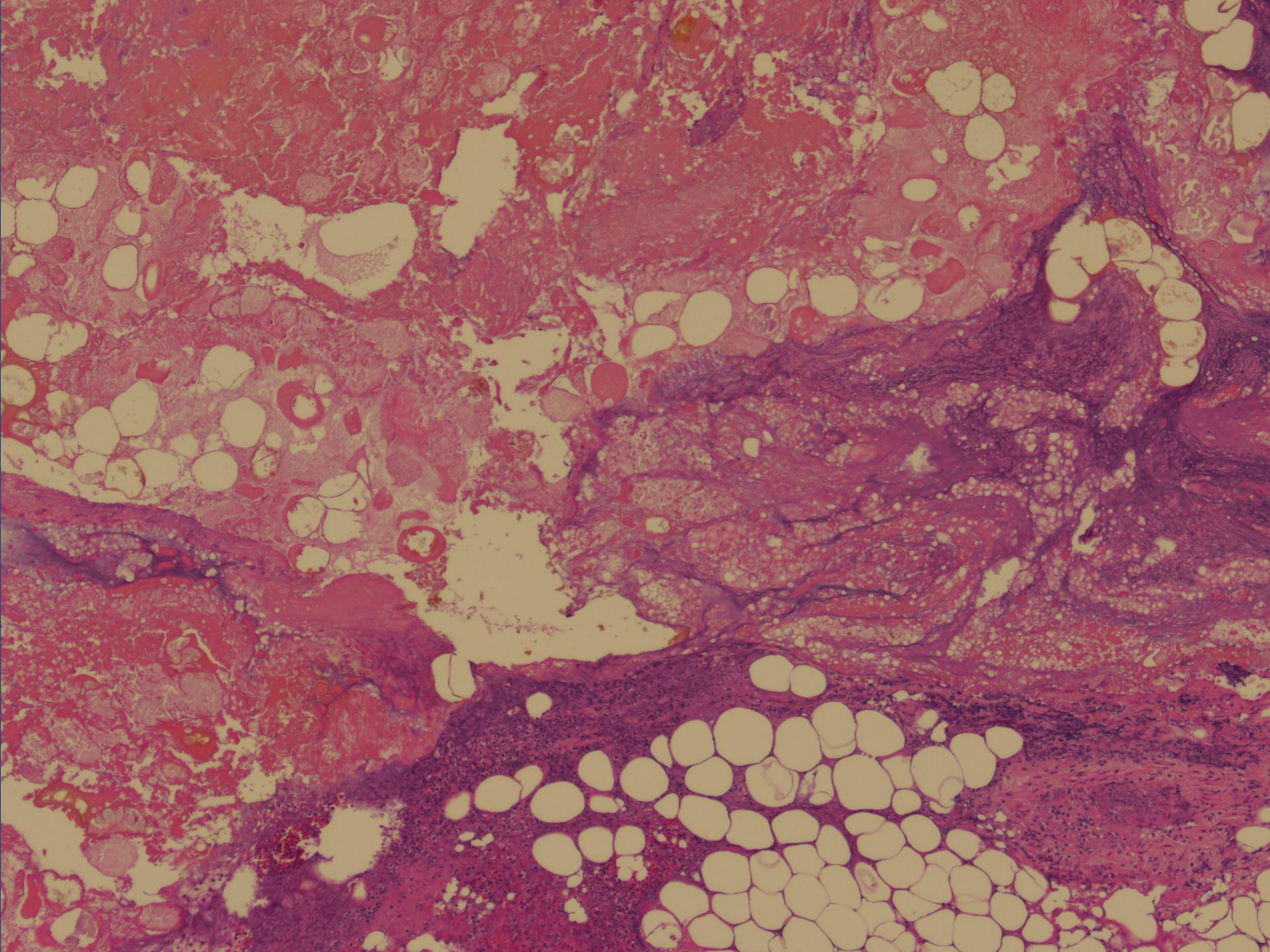


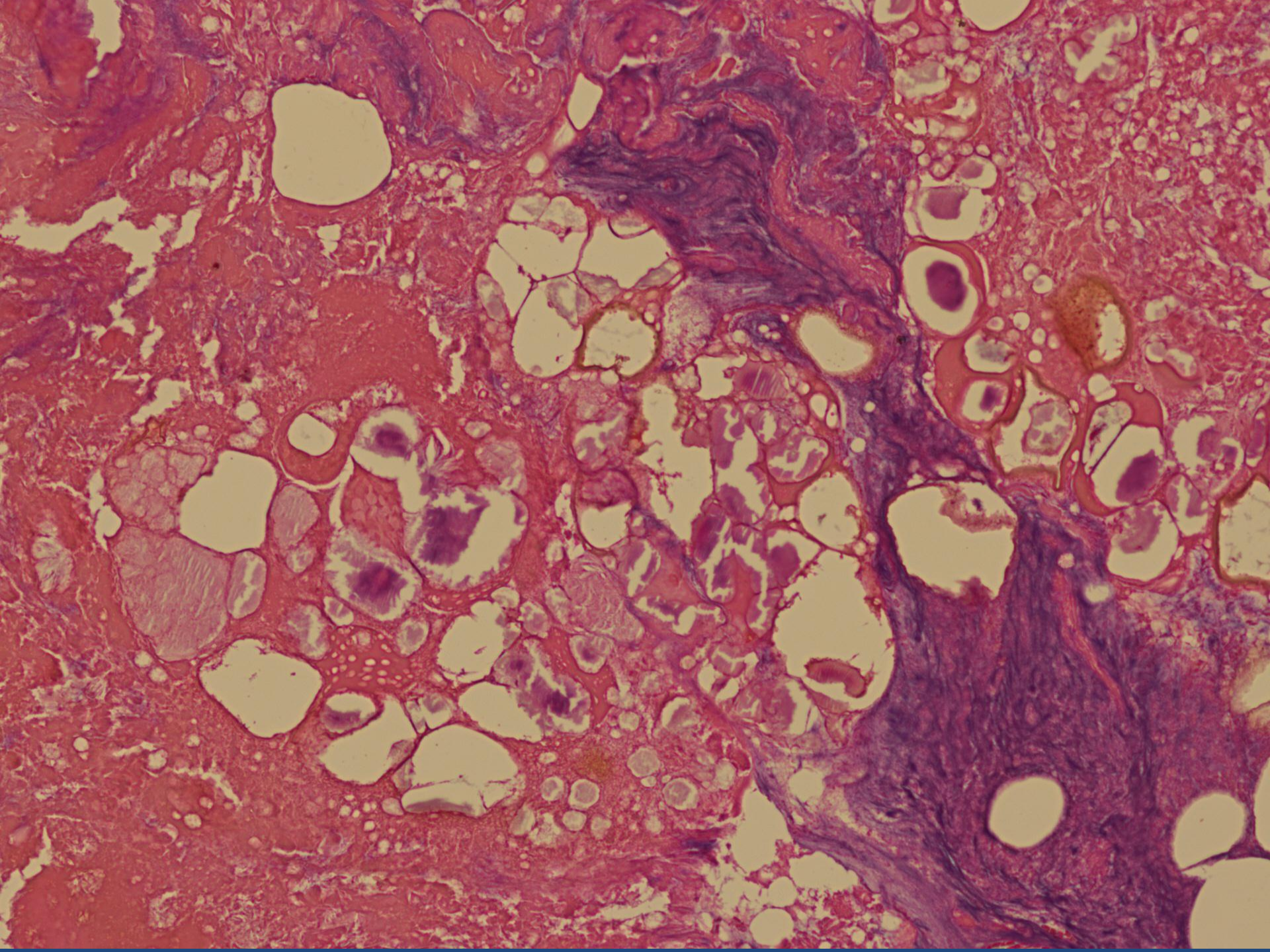














# Adenosquamous Carcinoma of Gallbladder

# Gallbladder Carcinoma

- Relatively uncommon
- Age 60+ years (mean 72 years), usually not resectable
- 90% are adenocarcinoma, 5% squamous cell or adenosquamous, 5% undifferentiated

# Epidemiology

- 2.5 per 100,000 population
- F : M = 1.77: 1
- Lower incidence in Asia, where pyogenic and parasitic disease of biliary tree are more common
- More common in American Indians and Hispanics; very rare in blacks
- Approximately 5000 new cases are discovered each year in US

# Etiology

- Gallstones
- Diffuse calcification of the GB wall (porcelain gallbladder)
- Abnormal junction between CBD and pancreatic duct (abnormal choledochopancreatic junction)
- Familial adenomatous polyposis (FAP)
- Ulcerative colitis
- Primary sclerosing cholangitis
  
- Squamous metaplasia of GB mucosa

# Clinical features

- Currently, close to 50% of GB carcinoma are diagnosed incidentally in cholecystectomy specimens from pts with s/s attributed only to the presence of gallstones.
- Unfortunately, gallbladder carcinoma usually presents at a late stage, even when found incidentally
- Abdominal pain, jaundice, weight loss

# Gross

- Infiltrating grey-white mass
- Most arise in GB fundus (60%) as nodular masses or diffusely involve the GB
- Body (30%), neck (10%)
- The GB may be distended by the tumor, or collapsed owing to obstruction of the neck or cystic duct

# Micro of Adenosquamous Ca

- The extent of differentiation of the two malignant components, glandular and squamous, varies, but in general they tend to be moderately-differentiated
- Keratin pearls are often present in the squamous component
- Mucin is usually demonstrable in the neoplastic glands.

## D.D.

- Cholecystitis with reactive atypia
- Carcinoma in situ colonizing Rokitansky-Aschoff sinuses (nonrounded, irregularly placed gland contours, single cells, and the presence of desmoplasia favor invasive ca)



# Prognosis

- GB ca tend to present at an advanced stage; 70% involve liver at diagnosis; 50% involve regional lymph nodes
- Overall prognosis is poor, with 5% to 10% survival at 5 years
- **5 year survival:**
  - Overall 1% ([J Surg Oncol 2008;98:485](#))
  - 85-100% for T1, 30-40% for T2
  - Median survival 6 months

# Prognostic factors

- Favorable: papillary histology, low stage
- Unfavorable: small cell or undifferentiated types, angiolymphatic invasion, poorly differentiated, high stage, tumor budding and dedifferentiation

# Prognostic factors

Molecular markers, poor prognosis:

- Overexpression of MCM2 or loss of expression of Tat-interacting protein 30 ([Hum Pathol 2011;42:1676](#)), overexpression of PEG10 and TSG101 ([Pathol Oncol Res 2011;17:859](#)), reduced expression of Raf-1 kinase inhibitory protein ([Hum Pathol 2010;41:1609](#))
- L1 adhesion molecule ([Hum Pathol 2011;42:1476](#))
- Strong cytoplasmic expression of COX2 at invasive fronts ([J Clin Pathol 2010;63:1048](#))

|            |  |
|------------|--|
| <b>TX</b>  | Primary tumor cannot be assessed   |
| <b>T0</b>  | No evidence of primary tumor   |
| <b>Tis</b> | Carcinoma in situ  |
| <b>T1a</b> | Tumor invades lamina propria   |
| <b>T1b</b> | Tumor invades muscular layer   |
| <b>T2</b>  | Tumor invades perimuscular connective tissue   |
| <b>T3</b>  | Tumor perforates serosa or directly invades the liver and/or one other adjacent organ              |
| <b>T4</b>  | Tumor invades main portal vein or hepatic artery or invades multiple extrahepatic organs           |
| <b>NX</b>  | Regional nodes cannot be assessed  |
| <b>N0</b>  | No regional nodal metastasis   |
| <b>N1</b>  | Metastasis to nodes along the cystic duct, common bile duct, hepatic artery and/or portal vein     |
| <b>N2</b>  | Metastasis to periaortic, pericaval, superior mesenteric artery, and/or celiac artery lymph nodes* |
| <b>M0</b>  | No distant metastasis  |
| <b>M1</b>  | Distant metastasis   |

|                   |       |       |    |
|-------------------|-------|-------|----|
| <b>Stage 0</b>    | Tis   | N0    | M0 |
| <b>Stage I</b>    | T1    | N0    | M0 |
| <b>Stage II</b>   | T2    | N0    | M0 |
| <b>Stage IIIA</b> | T3    | N0    | M0 |
| <b>Stage IIIB</b> | T1-3  | N1    | M0 |
| <b>Stage IVA</b>  | T4    | N0-1  | M0 |
| <b>Stage IVB</b>  | Any T | Any N | M0 |
|                   |       |       | M1 |

\* Denotes changes from 6<sup>th</sup> edition classification.