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Case Report

Gallbladder carcinoma presenting as hemobilia and overt gastrointestinal bleeding: a rare case report

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ABSTRACT

Gallbladder carcinoma (GBC) rarely presents as hemobilia or hemocholecyst. Intraluminal hemorrhage as the initial manifestation of gallbladder cancer is extremely uncommon, reported in nearly 1% of cases, with only a handful of cases described in the literature over the last three decades. A 54-year-old female presented with recurrent abdominal pain, melena, jaundice, and severe anemia requiring multiple blood transfusions. Repeated upper gastrointestinal endoscopies, colonoscopies, and contrast-enhanced computed tomography scans failed to identify the bleeding source initially. A subsequent upper gastrointestinal endoscopy demonstrated active blood ooze in the second part of the duodenum, raising suspicion of hemobilia. Further imaging revealed a gallbladder mass with common bile duct involvement. Exploratory surgery identified a gallbladder tumor with intraluminal blood clots extending into the common bile duct. The patient underwent radical cholecystectomy with liver wedge resection and en bloc excision of the common bile duct followed by Roux-en-Y hepaticojejunostomy. Histopathology confirmed grade 1 mucinous adenocarcinoma of the gallbladder (pT2a pN0). Postoperative recovery was uneventful, with no further episodes of gastrointestinal bleeding. This case highlights the diagnostic challenges of hemobilia in the absence of prior biliary intervention or trauma and emphasizes the importance of persistent evaluation and high clinical suspicion for early diagnosis of gallbladder malignancy presenting with obscure gastrointestinal bleeding.

Keywords: Gallbladder carcinoma, Hemobilia, Hemocholecyst, Gastrointestinal bleeding, Case report

INTRODUCTION

Gallbladder carcinoma is a relatively rare malignancy with poor prognosis due to late presentation. Approximately 60–70% of cases are detected incidentally during surgery for presumed benign gallbladder disease.[1] Known risk factors include cholelithiasis, porcelain gallbladder, gallbladder polyps, chronic infections, congenital biliary anomalies, obesity, and certain medications.[2]

Adenocarcinoma is the most common histological subtype, accounting for nearly 76% of gallbladder neoplasms.[3] Although gallbladder cancer may present with varied atypical manifestations, intraluminal hemorrhage leading to hemobilia or hemocholecyst is among the rarest presentations, occurring in approximately 1% of cases.[4]

We report a rare case of gallbladder carcinoma presenting as recurrent overt gastrointestinal bleeding due to hemobilia, posing significant diagnostic difficulty.

CASE REPORT

A 54-year-old woman presented with right upper abdominal pain for three months, melena, recurrent vomiting, and jaundice for one month. She denied hematemesis but reported anorexia and weight loss. She was a known case of type 2 diabetes mellitus on oral hypoglycemic agents.

In May 2023, she was evaluated for anemia secondary to gastrointestinal bleeding. Upper gastrointestinal endoscopy and colonoscopy were normal. She was advised

further imaging and small bowel enteroscopy but was lost to follow-up. She re-presented in September 2023 with recurrent anemia and received blood transfusions. Ultrasonography suggested cholelithiasis with organized sludge and possible mass lesion. Triple-phase contrast-enhanced computed tomography (CT) revealed cholelithiasis with dilated common bile duct and intrahepatic biliary radicals.

Despite repeated hospital visits and blood transfusions, CT angiography and repeat endoscopic evaluations remained inconclusive. In February 2024, upper gastrointestinal endoscopy demonstrated blood clots and active ooze in the second part of the duodenum, suggestive of hemobilia. Subsequent imaging (triple phase CECT W/A) revealed a heterogeneously enhancing gallbladder mass extending from the neck into the cystic duct with contiguous involvement of the common bile duct up to the ampulla (Figure 1).

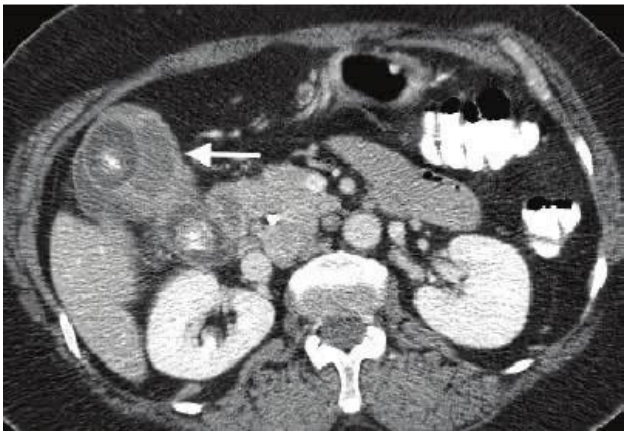

Figure 1: Triple-phase contrast-enhanced CT (CECT) of the abdomen showing a heterogeneously enhancing gallbladder mass.

Magnetic resonance cholangiopancreatography showed dilated intra- and extrahepatic bile ducts with abrupt tapering near the proximal common bile duct. Tumor markers (CEA and CA 19-9) were within normal limits. Endoscopic retrograde cholangiopancreatography revealed narrowing of the upper common bile duct, for which sphincterotomy and stenting were performed. Post-procedure, the patient developed retroperitoneal air suggestive of duodenal perforation and was managed conservatively.

Whole-body PET-CT demonstrated mildly FDG-avid gallbladder wall thickening (Figure 2) with hyperdense non-FDG-avid intraluminal contents, suggestive of hemorrhage. A provisional diagnosis of gallbladder carcinoma was made.

The patient underwent exploratory laparotomy. Intraoperatively, a palpable intraluminal growth was noted in the gallbladder fundus with thickened cystic duct and common bile duct containing blood clots. Radical cholecystectomy with liver wedge resection and en bloc excision of the common bile duct followed by Roux-en-Y hepaticojejunostomy was performed.

Histopathology revealed grade 1 mucinous adenocarcinoma of the gallbladder involving the fundus and body (pT2a pN0). Postoperative recovery was uneventful with no further drop in hemoglobin. The patient completed six cycles of adjuvant chemotherapy and remains under regular follow-up.

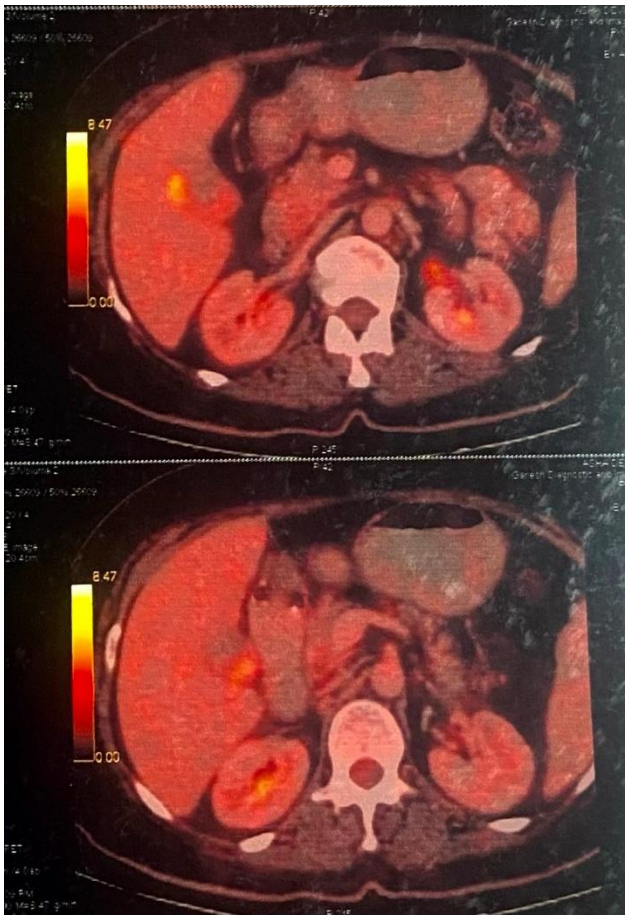

Figure 2: Whole-body PET-CT showing mildly FDG-avid uptake in the gallbladder.

DISCUSSION

Hemobilia, defined as bleeding into the biliary tree, was first described in 1948 and remains a rare cause of upper gastrointestinal bleeding, accounting for 2–5% of cases.[5] Its classic triad includes right upper quadrant pain, jaundice, and gastrointestinal bleeding, though all three features are present in a minority of patients.

Hemocholecyst refers to hemorrhage confined within the gallbladder without rupture and is an exceedingly rare presentation of gallbladder tumors, reported in less than 1% of cases.[6] Diagnosis is challenging, particularly in patients without prior hepatobiliary interventions or trauma.

Upper gastrointestinal endoscopy remains the most useful diagnostic modality, identifying hemobilia in over 60% of cases.[7] Cross-sectional imaging and angiography play complementary roles when endoscopy is inconclusive.

This case underscores the importance of repeated and persistent evaluation in patients with obscure gastrointestinal bleeding, as delayed recognition may adversely affect outcomes in gallbladder carcinoma.

CONCLUSION

Gallbladder carcinoma presenting as hemobilia and hemocholecyst is extremely rare and poses significant diagnostic challenges. Persistent investigation and a high index of suspicion are crucial for timely diagnosis. This case highlights the importance of considering gallbladder malignancy in patients with unexplained recurrent gastrointestinal bleeding and anemia, enabling early surgical intervention and improved outcomes.

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