AN OVERVIEW ON DIAGNOSIS AND SURGICAL MANAGEMENT OF GALLBLADDER CANCER

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ABSTRACT

Gallbladder cancer is among the most deadly cancers, and it continues to present surgeons with numerous challenges. Cholelithiasis, an abnormal pancreaticobiliary junction, and focal mucosal microcalcifications are all known risk factors for gallbladder carcinoma. The most common histologic type in most patients is adenocarcinoma, which is frequently associated with Kras and p53 mutations. Endoscopic ultrasonography, magnetic resonance cholangiopancreatography, as well as helical computed tomography, as well as radiologic or endoscopic improvements in endoscopic ultrasonography as well as magnetic resonance cholangialpancratia, have improved preoperative staging. Cholecystectomy (subsegmental surgical excision of segments IVB but instead V plus a hepatoduodenal ligament lymphadenectomy) for advanced disease without indications of distant metastasis (T2-4/N0-N2) or a radical cholecystectomy (subsegmental resection of segments IVB as well as V plus a hepatoduodenal musculotendinous lymphadenectomy) for severe stages without indications of distant metastasis More extensive hepatic resection, such as extended right hepatectomy or central segmentectomy with caudate lobectomy, has been recommended by certain surgeons. Patients who underwent a pancreaticoduodenectomy to enhance distal ductal margins as well as lymphadenectomy for T3 or T4 malignancies were studied by Japanese surgeons. These patients had a reduced incidence of tumor recurrence but no benefit in terms of survival. Adjuvant treatment options are still restricted. The most frequent postoperative treatment is radiation therapy with fluorouracil radio sensitization. Capecitabine, oxaliplatin, & bevacizumab are now being studied in the treatment of gallbladder cancer in clinical studies.

KEYWORDS: *Biliary, Cancer, Cholecystectomy, Endoscopic, Gallbladder.*

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