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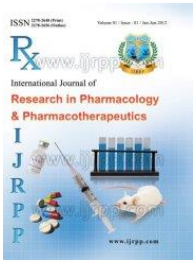

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Case Report ***Open Access***

Case report on klatskin tumor

Dr.Peddapalli Appa Rao[1*], Dr. K V Subrahmanyam[2*], Dr. Sandhya Rani[3], Dr. Shazia Yousuf[4]

[1]*Research Centre: IMMA Labs, Hyderabad.*
[2, 3, 4]*Samskuti College of Pharmacy, Kondapur, Ghatkesar, R.R District, Hyderabad.*

***Corresponding author: Dr. Peddapalli Appa Rao, Dr. K. V. Subrahmanyam**
Email: vatavapparao@gmail.com

ABSTRACT

Klatskin Tumor also known as Hilar Cholangiocarcinoma is a cancer that affect Bilary tree predominantly at the bifurcation of the common hepatic duct. Of all diagnosed cancers, Cholangiocarcinoma accounts for approximately 2% with an overall incidence of 1.2 per 100,000 individuals. The etiology of cholangiocarcinoma is undefined although Primary sclerosing cholangitis has been clearly associated with the development of cholangiocarcinoma in up to 40% of patients. A 45 year old male patient presented to surgical OPD with complaints of severe pain in abdomen, vomitings and pruritis with severe jaundice. The Past Medical History indicates that the patient had high grade intermittent fever,Watery diarrhoea 4-5 episodes /day since two days. His personal history revealed of decreased appetite since one month and yellowing discolouration of eyes and trunk since one month. The Condition was evaluated using specific Diagnostic procedures like computed Tomography and Ultrasonography of Abdomen, Magnetic Resonance Cholangiopancreatography and laboratory findings like LFT which confirmed for Hilar Cholangiocarcinoma. The patient started Dr.Appa Raos treatment on the day of his visit and used medication for one month. A remarkable improvement was noted with Dr.Appa Raos treatment and the patient turned well.

Keywords: Cholangiocarcinoma, Klatskin tumor, MRCP.

INTRODUCTION

Bile duct cancer also known as Cholangiocarcinoma is the malignant tumor of the bile ducts that may arise anywhere along the biliary tree. The annual incidence of cholangicarcinoma is constantly increasing. In the Western countries, its incidence is estimated as 1-2 cases per 100 000 whereas in the northeastern Asia, its 96 cases per 100 000. It ac-counts for approximately 1.3% to 2.6% of annual cancer-related deaths worldwide. The Cholangiocarcinomas are categorised as intrahepatic, hilar or ex-trahepatic. Of these, hilar Cholangiocarcinoma is the common one which involves bifurcating site of the common hepatic duct, where they are referred to as Klatskin tumors. Klatskin tumor predominantly show signs of biliary obstruction with jaundice and pale stools which is evident in this case [1].

Cholangiocarcinoma is considered to be an untreatable and rapidly lethal cancer. There exist no potentially curative for this condition except surgery, but most people move to advanced stage of disease at presentation and eventually are inoperable at the time of diagnosis. People with cholangiocarcinoma are generally managed with chemotherapeutic agents, radiation therapy, and other palliative care measures. An abnormal liver function tests, yellowing of the eyes and skin occurring due to blocked of bile duct by tumor, severe abdominal pain, generalized itching, weight loss, changes in stool or urine color and fever are the common indications of Cholangiocarcinoma [2].

Cholangiocarcinoma can affect the bile ducts that are either within or outside the liver. Tumors that occur in the bile ducts living within the liver are referred to as intrahepatic while those tumors occurring in the bile ducts living outside the liver are extrahepatic, and tumors occurring at the site where the bile ducts exit the liver is referred to as perihilar. A cholangiocarcinoma occurring at the bifurcation where the left and right hepatic ducts meet to form the common hepatic duct is referred to as a Klatskin tumor [3].

Cholangiocarcinoma is known to develop from early hyperplasia and metaplasia, through dysplasia, to the development of frank carcinoma. This progress through chronic inflammation and obstruction of the bile ducts, resulting impaired bile flow.Histologically, cholangiocarcinomas may vary from undifferentiated to well-differentiated. These tumor cells are often surrounded by a brisk fibrotic or desmoplastic tissue response [4, 5].

CASE REPORT

A 45 year old male patient presented to surgical OPD on 29th May 2012 with history of yellowing discoloration of eyes and trunk since one month. It was iated with high grade intermittent fever. There was history of decreased appetite since one month. Watery diarrhoea 4-5 episodes /day since two days. Patient sought treatment in another hospital where he was diagnosed with jaundice with increase in bilirubin level to 20.3 from 5.6 mg/dl in 4-5 days. On examination patient was conscious and icterus was positive in bulbar, conjunctivae and over trunk.patient was admitted for further evaluation and management. Complete blood picture showed hemoglobin 11.3g/dl, RBC 3.71 million/cc and WBC 17500 cells/cc. Platelets were 1.34 lakhs/cc. ESR was 62 mm at 1st hour. Patient was nonreactive to HIV I and II and was HBs Ag negative.

Blood urea, serum creatinine and electrolytes were in common range. Liver function test revealed total bilirubin 22.1mg/dl , direct bilirubin 16.6 mg/dl, alkaline phosphatase 467 U/L. Ultrasound abdomen was done which revealed gross Intrahepatic billiary radicles (IHBRD) with ill-defined mass at porta, common billiary duct (CBD) not visualised suggestive of colangiocarcinoma.

MRCP was suggested for better evaluation which confirmed hilarcolagiocarcinoma with moderate IHBD dilation with extension into left duct. Patient was advised to report to Asian institute of Gastroentrology, Hyderabad for PTBD with stenting. On 2nd June 2012, CT abdomen – liver triphasic study was done at Asian Institute of Gastroenterology, which confirmed hilar colangiocarcinoma involving the confluence (Klatskin tumor) with extensions into the left lobe with extension into CHD and cystic duct along with moderate IHBD dilation on both lobed of liver. Gall bladder was contracted with calculi. He underwent percutaneous billiary stent (SEMS) placement across the stricture.

Post procedure patient was hemodynamically stable. USG guided screening was done after 48 hours which showed right sided pneumobilia and mild left IHBD. Left lobe atrophy was noted. He was discharged on 4th June 2012 in stable condition. Weight at discharge was 69 kgs. On 25th July 2012 he visited Dr.Appa Raos clinic in grave condition. He had severe pain abdomen, vomiting and pruritis with severe jaundice. He started Dr.Appa Raos treatment on the same day and used his medication for one month.

Treatment schedule and follow-up

Injection Human normal immunoglobulin, a Human Gamma Globulin Containing Mainly Immunoglobulin G (IgG) is given at a dose of 12 mg in combination with histamine dihydrochloride 0.15 mcg. 2 vials of this was given once in 3days followed by 2 vials once in a week for 8 weeks. Prednisilone having anti-inflammatory action is also added in tapered dose which is maintained 5 mg per day. Ranitidine, inhibitor of the action of histamine at the H_2 receptors found in gastric parietal cells is prescribed as 150 mg per day Before Food. The

patient was counseled and advised to restrict Tomato, Banana fruit, Prawns and milk in daily life.

After treatment, on 21st August 2012 total bilurubin was decreased to 2.4 mg/dl and direct bilurubin to 1.2 mg/dl. MRCP done on 22nd August 2012 stated significant reduction in the IHBD dilation in both lobes of liver, more in right lobe, compared to previous MRI dated 30th May 2012. Mild IHBD dilation of left lobe with CBD stent was done insitu. Again LFT done on 29th January 2013 showed total bilurubin further decreased to 1 mg/dl with direct bilurubin reduced to 0.3 mg/dl.

DISCUSSION

The following positive changes were noted from patients Liver function test after the given therapy.

.		Day 1 (29th May)	31st August	29th December
1.	Serum Bilirubin	22 mg%	2.4mg%	1mg%
2.	SGPT	59 U/L	32 U/L	29 U/L
3.	SGOT	100 U/L	48 U/L	34 U/L
4.	Alkaline Phosphatase	467 U/L	728 U/L	382 U/L

Dr.Appa Raos medication has worked very well.

CONCLUSION

Thus if we can initiate the cancer management with immunotherapy in the early onset, the chances of recovery is more. As these immuno-nutritive therapies are harmless, economical and easy to administer, these experiences of Dr.AppaRao are more valid to consider for Investigation in the good interest of mankind.

Conflicts of interest

There are no conflicts of interest.

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