Homerton Hospital Radiology Guidelines for gallbladder polyp follow-up

This document pertains to the follow-up of gallbladder polyps which are discovered incidentally on US.

**INTRODUCTION**
Gallbladder polyps are outgrowths of the gallbladder mucosal wall and their clinical significance relates primarily to malignant potential. The size of the polyp and presence or absence of gallstones are the two most important factors in determining malignant potential and therefore management.

Gallbladder polyps are identified in 1.5 – 4.5% of routine abdominal US examinations (1,2).

**CLASSIFICATION**
Polypoidal lesions can be benign or malignant. Benign lesions can be divided into neoplastic or non-neoplastic.

**Benign lesions:**
Neoplastic
Adenoma – The most common benign lesion.
Leiomyomas, Lipomas.

Non-neoplastic
Cholesterol polyps (“cholesterolosis”)
Adenomyomas/ademomyomatosis
Inflammatory polyps

**Malignant lesions:**
Adenocarcinoma – Much more common than adenomas.
Squamous cell carcinomas
Mucinous cystadenomas

**RISK OF MALIGNANCY**
Polyps over 2cm are almost always malignant.

Polyps 1 to 2cm in size should be regarded as possibly malignant.

Polyps under 1cm are very unlikely to be malignant. Polyps under 1cm in size are 25 times less likely to be malignant than those greater than 1cm (3).
RECOMMENDATIONS

1. Polyps on a background of gallstones or primary sclerosing cholangitis
Patients with gallbladder polyp(s) and concomitant gallstones should be referred for cholecystectomy regardless of the polyp size or the presence of symptoms. Gallstones and primary sclerosing cholangitis are risk factors for gallbladder cancer in patients with gallbladder polyp(s).

2. Symptomatic patients
Cholecystectomy is recommended in patients with biliary colic or pancreatitis secondary to gallbladder polyps.

3. Asymptomatic patients with polyps over 2cm
Polyps over 2cm are usually malignant and a surgical referral with a view to resection is advised with a pre-operative CT and endoscopic ultrasound for staging.

4. Asymptomatic patients with polyps between 1cm and 2cm
Surgical referral for laparoscopic cholecystectomy is recommended.

5. Asymptomatic patients with polyps measuring 5mm to 10mm
A follow-up US at 6 months and 1 year is advised and yearly if there is no interval change in size. If there is an interval increase in size then a surgical referral is advised.

6. Asymptomatic patients with polyps measuring under 5mm
A follow-up US at 6 months and 1 year is advised. No further imaging is required if the polyp is stable.
REFERENCES