Gallbladder Cancer Early Detection, Diagnosis, and Staging

Detection and Diagnosis

Catching cancer early often allows for more treatment options. Some early cancers may have signs and symptoms that can be noticed, but that is not always the case.

- Can Gallbladder Cancer Be Found Early?
- Signs and Symptoms of Gallbladder Cancer
- How Is Gallbladder Cancer Diagnosed?

Stages and Outlook (Prognosis)

After a cancer diagnosis, staging provides important information about the extent of cancer in the body and anticipated response to treatment.

- How Is Gallbladder Cancer Staged?
- Survival Statistics for Gallbladder Cancer by Stage

Questions to Ask About Gallbladder Cancer

Here are some questions you can ask your cancer care team to help you better understand your cancer diagnosis and treatment options.

- What Should You Ask Your Doctor About Gallbladder Cancer?

Can Gallbladder Cancer Be Found Early?
Gallbladder cancer is hard to find early. The gallbladder is deep inside the body, so early tumors can’t be seen or felt during routine physical exams. There are no blood tests or other tests that can reliably detect gallbladder cancers early enough to be useful as screening tests. (Screening is testing for cancer in people without any symptoms.) Because of this, most gallbladder cancers are found only after the cancer has grown enough to cause signs or symptoms.

Still, some gallbladder cancers are found before they have spread to other tissues and organs. Many of these early cancers are found unexpectedly when a person’s gallbladder is removed because of gallstones. When the gallbladder is looked at in the lab after it is removed, small cancers or pre-cancers that did not cause any symptoms are sometimes found.

- References

See all references for Gallbladder Cancer

Last Medical Review: October 29, 2014 Last Revised: February 5, 2016

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**Signs and Symptoms of Gallbladder Cancer**

Gallbladder cancer does not usually cause signs or symptoms until later in the course of the disease, but sometimes symptoms can appear sooner and lead to an early diagnosis. If the cancer is found at an earlier stage, treatment might be more effective.

Some of the more common symptoms of gallbladder cancer are:

**Abdominal (belly) pain**

Most people with gallbladder cancer will have abdominal pain. Most often this is in the upper right part of the belly.

**Nausea and/or vomiting**
People with gallbladder cancer sometimes have vomiting as a symptom.

**Jaundice**

Jaundice is a yellowing of the skin and the white part of the eyes. If the cancer grows large enough to block the bile ducts, bile from the liver can't drain into the intestines. This can cause bilirubin (a chemical in bile that gives it a yellow color) to build up in the blood and settle in different parts of the body. This can often be seen in the skin and eyes.

**Lumps in the belly**

If the cancer blocks the bile ducts, the gallbladder can swell to larger than normal. Gallbladder cancer can also spread to nearby parts of the liver. These can sometimes be felt by the doctor as lumps on the right side of the belly. They can also be detected by imaging tests such as an ultrasound.

**Other symptoms**

Less common symptoms of gallbladder cancer include:

- Loss of appetite
- Weight loss
- Swelling in the abdomen (belly)
- Fever
- Itchy skin
- Dark urine
- Light-colored or greasy stools

Gallbladder cancer is not common, and these symptoms and signs are more likely to be caused by something other than gallbladder cancer. For example, people with gallstones also have many of these symptoms. There are many far more common causes of abdominal pain than gallbladder cancer. And viral hepatitis (infection of the liver) is a much more common cause of jaundice. Still, if you have any of these problems, it’s important to see your doctor right away so the cause can be found and treated, if needed.

- References

[See all references for Gallbladder Cancer]
How Is Gallbladder Cancer Diagnosed?

Some gallbladder cancers are found after the gallbladder has been removed to treat gallstones or chronic (long-term) inflammation. Gallbladders removed for those reasons are always looked at under a microscope to see if they contain cancer cells.

Most gallbladder cancers, though, are not found until a person goes to a doctor because they have symptoms.

Medical history and physical exam

If you have any signs or symptoms that suggest you might have gallbladder cancer, your doctor will want to take a complete medical history to check for risk factors and to learn more about your symptoms.

Your doctor will examine you to look for signs of gallbladder cancer and other health problems. The exam will focus mostly on the abdomen to check for any lumps, tenderness, or buildup of fluid. The skin and the white part of the eyes will be checked for jaundice (a yellowish color). Sometimes, cancer of the gallbladder spreads to lymph nodes, causing a lump that can be felt beneath the skin. Lymph nodes above the collarbone and in several other locations may be examined carefully.

If symptoms and/or the physical exam suggest you might have gallbladder cancer, other tests will be done. These might include lab tests, imaging tests, and other procedures.

Blood tests

Tests of liver and gallbladder function

Your doctor may order lab tests to find out how much bilirubin is in the blood. Bilirubin is the chemical that gives the bile its yellow color. Problems in the gallbladder, bile ducts,
or liver can raise the blood level of bilirubin. A high bilirubin level tells the doctor that there may be gallbladder, bile duct, or liver problems.

The doctor may also order tests for other substances in your blood, such as albumin, alkaline phosphatase, AST, ALT, and GGT, which can also be abnormal if you have liver, bile duct, or gallbladder disease. These are sometimes referred to as liver function tests.

**Tumor markers**

CEA and CA 19-9 are tumor markers (proteins found in the blood when certain cancers are present). High levels of these substances are often (but not always) found in people with gallbladder cancer. Usually the blood levels of these markers are high only when the cancer is in an advanced stage. These markers are not specific for gallbladder cancer – that is, other cancers or even some other health conditions can cause high levels.

These tests can sometimes be useful after a person is diagnosed with gallbladder cancer. If the levels of these markers are found to be high, they can be followed over time to help tell how well treatment is working.

**Imaging tests**

Imaging tests use x-rays, magnetic fields, or sound waves to create pictures of the inside of your body. Imaging tests can be done for a number of reasons, including:

- To look for suspicious areas that might be cancer
- To help a doctor guide a biopsy needle into a suspicious area to take a sample
- To learn how far cancer has spread
- To help guide certain types of treatments
- To help determine if treatment is working
- To look for signs of the cancer coming back after treatment

People who have (or might have) gallbladder cancer may have one or more of the following tests.

**Ultrasound**

For this test, a small instrument called a transducer gives off sound waves and picks up their echoes as they bounce off organs inside the body. The echoes are converted by a
computer into an image on a screen. The patterns of echoes can help find tumors and show how far they have grown into nearby areas.

**Abdominal ultrasound:** This is often the first imaging test done in people who have symptoms (such as jaundice or pain in the right upper part of their abdomen) that might be caused by gallbladder problems.

This is an easy test to have done, and it uses no radiation. You simply lie on a table while the doctor or ultrasound technician moves the transducer (which is shaped like a wand) along the skin over the right upper abdomen. Usually, the skin is first lubricated with gel.

**Endoscopic or laparoscopic ultrasound:** In these techniques, the doctor puts the ultrasound transducer inside the body and closer to the gallbladder, which gives more detailed images than a standard ultrasound. The transducer is on the end of a thin, lighted tube that has an attached viewing device. The tube is either passed through the mouth, down through the stomach, and near the gallbladder area (*endoscopic ultrasound*) or through a small surgical cut in the belly (*laparoscopic ultrasound*).

If there is a tumor, ultrasound might help the doctor tell if and how far it has invaded the gallbladder wall, which helps in planning for surgery. Ultrasound may be able to show if nearby lymph nodes are enlarged, which can be a sign that cancer has reached them.

Ultrasound can also be used to guide a needle into a suspicious lymph node so that cells can be removed (biopsied) and viewed under a microscope. This is known as an *ultrasound-guided needle biopsy*.

**Computed tomography (CT) scan**

The CT scan uses x-rays to make detailed cross-sectional images of your body. Instead of taking one picture, like a regular x-ray, a CT scanner takes many pictures as it rotates around you while you lie on a table. A computer then combines these into images of slices of the part of your body that is being studied.

A CT scanner has been described as a large donut, with a narrow table that slides in and out of the middle opening. You will need to lie still on the table while the scan is being done. CT scans take longer than regular x-rays, and you might feel a bit confined by the ring while the pictures are being taken.

Before any pictures are taken, you might be asked to drink 1 to 2 pints of a liquid called *oral contrast*. This helps outline the intestine so that certain areas are not mistaken for
tumors. You might also need an IV (intravenous) line through which a different kind of contrast dye (IV contrast) is injected. This helps better outline structures throughout your body.

The injection can cause some flushing (redness and warm feeling). Some people are allergic and get hives or, rarely, more serious reactions like trouble breathing and low blood pressure. Be sure to tell the doctor if you have any allergies or have ever had a reaction to any contrast material used for x-rays.

CT scans can have several uses for gallbladder cancer:

- They are often used to help diagnose gallbladder cancer by showing tumors in the area.
- They can help stage the cancer (find out how far it has spread). CT scans can show the organs near the gallbladder (especially the liver), as well as lymph nodes and distant organs the cancer might have spread to.
- A type of CT known as CT angiography can be used to look at the blood vessels near the gallbladder. This can help determine if surgery is a treatment option.
- CT scans can also be used to guide a biopsy needle into a suspected tumor or metastasis. For this procedure, called a CT-guided needle biopsy, you remain on the CT scanning table, while the doctor advances a biopsy needle through the skin and toward the mass. CT scans are repeated until the needle is within the mass. A biopsy sample is then removed and looked at under a microscope.

Magnetic resonance imaging (MRI) scan

Like CT scans, MRI scans provide detailed images of soft tissues in the body. But MRI scans use radio waves and strong magnets instead of x-rays. A contrast material called gadolinium may be injected into a vein before the scan to better see details.

MRI scans provide a great deal of detail and can be very helpful in looking at the gallbladder and nearby bile ducts and other organs. Sometimes they can help tell a benign tumor from a cancerous one.

Special types of MRI scans can also be used in people who may have gallbladder cancer:

- **MR cholangiopancreatography (MRCP)**, which can be used to look at the bile ducts, is described below in the section on cholangiography.
- **MR angiography (MRA)**, which looks at blood vessels, is mentioned below in the
MRI scans can be a little more uncomfortable than CT scans. They take longer, often up to an hour. You may have to lie inside a narrow tube, which is confining and can upset people who have a fear of enclosed spaces. Special, more open MRI machines can sometimes be used instead. The MRI machine also makes buzzing and clicking noises that might be disturbing. Some places will provide earplugs to help block this noise out.

Cholangiography

A cholangiogram is an imaging test that looks at the bile ducts to see if they are blocked, narrowed, or dilated. This can help show if someone might have a tumor that is blocking a duct. It can also be used to help plan surgery. There are several types of cholangiograms, each of which has different pros and cons.

**Magnetic resonance cholangiopancreatography (MRCP):** This is a non-invasive way to take images of the bile ducts using the same type of machine used for standard MRI scans. It does not require use of a contrast agent and is not invasive, unlike other types of cholangiograms. Because it is non-invasive, doctors often use MRCP if the purpose of the test is just to image the bile ducts. But this test can’t be used to get biopsy samples of tumors or to place stents (small tubes) in the ducts to keep them open.

**Endoscopic retrograde cholangiopancreatography (ERCP):** In this procedure, a doctor passes a long, flexible tube (endoscope) down the throat, through the esophagus and stomach and into the first part of the small intestine. This is usually done while you are sedated (given medicine to make you sleepy). A small catheter (tube) is passed from the end of the endoscope and into the common bile duct. A small amount of contrast dye is injected through the tube to help outline the bile ducts and pancreatic duct as x-rays are taken. The images can show narrowing or blockage of these ducts.

This test is more invasive than MRCP, but the advantage is that the doctor can also take samples of cells or fluid to look at under a microscope. ERCP can also be used to place a stent (a small tube) into a duct to help keep it open.

**Percutaneous transhepatic cholangiography (PTC):** In this procedure, the doctor places a thin, hollow needle through the skin of the belly and into a bile duct within the liver. You will get medicine through an IV line to make you sleepy before the test. A local anesthetic is also used to numb the area before inserting the needle. A contrast dye is then injected through the needle, and x-rays are taken as it passes through the bile ducts. As with ERCP, this approach can also be used to take samples of fluid or tissues or to place a stent into a duct to help keep it open. Because it is more invasive (and might cause more pain), PTC is not usually used unless ERCP has already been
tried or can’t be done for some reason.

**Angiography**

Angiography or an angiogram is an x-ray test used to look at blood vessels. For this test, a small amount of contrast dye is injected into an artery to outline blood vessels while x-ray images are taken. The images show if blood flow in an area is blocked or affected by a tumor, and any abnormal blood vessels in the area. The test can also show if a gallbladder cancer has grown through the walls of certain blood vessels. This information is used to help surgeons decide whether a cancer can be removed and to help plan the operation.

X-ray angiography can be uncomfortable because the doctor has to put a small catheter (a flexible hollow tube) into the artery leading to the gallbladder to inject the dye. Usually the catheter is put into an artery in your inner thigh and threaded up into the artery supplying the gallbladder. A local anesthetic is often used to numb the area before inserting the catheter. Then the dye is injected quickly to outline all the vessels while the x-rays are being taken.

Angiography can also be done with a CT scanner (CT angiography) or an MRI scanner (MR angiography). These techniques are now used more often because they can give information about the blood vessels near the gallbladder without the need for a catheter in the artery. You may still need an IV line so that contrast dye can be injected into the bloodstream during the imaging.

**Laparoscopy**

Laparoscopy is a type of minor surgery. The doctor inserts a thin tube with a light and a small video camera on the end (a laparoscope) through a small incision (cut) in the front of the abdomen to look at the gallbladder, liver, and other organs. (Sometimes more than one cut is made.) This procedure is done in the operating room while you are under general anesthesia (in a deep sleep).

Laparoscopy can help doctors plan surgery or other treatments, and can help determine the stage (extent) of the cancer. If needed, doctors can also insert instruments through the incisions to remove biopsy samples, which are then looked at under a microscope to make or confirm the diagnosis of cancer.

Laparoscopy is often used to remove the gallbladder to treat gallstones or chronic inflammation of the gallbladder. This operation is called a laparoscopic
If gallbladder cancer is found or suspected during that operation, surgeons usually convert the operation to an *open cholecystectomy* (removal of the gallbladder through a larger cut in the abdomen). The open method lets the surgeon see more and may lower the chance of releasing cancer cells into the abdomen when the gallbladder is removed. The use of the open procedure depends on the size of the cancer and whether surgery can remove all the cancer.

**Biopsy**

During a biopsy, the doctor removes a tissue sample to be looked at under a microscope to see if cancer (or some other disease) is present. For most types of cancer, a biopsy is needed for a diagnosis. Biopsies are also used to help find out how far the cancer has spread. This is important when determining the best treatment options.

But a biopsy may not always be done before surgery to remove a gallbladder tumor. Doctors are often concerned that sticking a needle into the tumor or otherwise disturbing it without completely removing it might allow cancer cells to spread to other areas.

If imaging tests (ultrasound, CT or MRI scans, cholangiography, etc.) suggest there is a tumor in the gallbladder and there are no obvious signs of distant spread, the doctor may decide to proceed directly to surgery and to treat it as a gallbladder cancer. (See “[Surgery for gallbladder cancer](#)”.) In these cases, the gallbladder tissue is looked at under a microscope after the gallbladder is removed.

In other cases, a doctor may feel that a biopsy of a suspicious area in the gallbladder is the best way to know for certain if it is cancer. For example, imaging tests may show that a tumor has spread or grown too large to be removed completely by surgery. Unfortunately, many gallbladder cancers are not removable by the time they are first found.

**Types of biopsies**

There are several ways to take biopsy samples of the gallbladder.

If cholangiography (ERCP or PTC) is being done, a sample of bile may be collected during the procedure to look for cancer cells within the fluid.

As noted earlier, biopsy specimens can be taken during laparoscopy. This lets the
doctor see the surface of the gallbladder and nearby areas and take samples of suspicious areas.

If the cancer appears to be too advanced for surgery, a needle biopsy may be done to confirm the diagnosis and help guide treatment. For this test, a thin, hollow needle is inserted through the skin and into the tumor without making a surgical incision. (The skin is numbed first with a local anesthetic.) The needle is usually guided into place using ultrasound or CT scans. When the images show that the needle is in the tumor, a sample is drawn into the needle and sent to the lab to be viewed under a microscope.

In most cases, this is done as a fine needle aspiration (FNA) biopsy, which uses a very thin needle attached to a syringe to suck out (aspirate) a sample of cells. If this isn’t successful, a core needle biopsy, which uses a slightly larger needle to get a bigger sample, may be done. Doctors don’t usually do a core needle biopsy first because it has a higher chance of spreading cancer cells.

For more information about biopsies and how they are tested, see Testing Biopsy and Cytology Specimens for Cancer.

- References

See all references for Gallbladder Cancer

Last Medical Review: October 29, 2014 Last Revised: February 5, 2016

Gallbladder Cancer Stages

After someone is diagnosed with gallbladder cancer, doctors will try to figure out if it has spread, and if so, how far. This process is called staging. The stage of a cancer describes how much cancer is in the body. It helps determine how serious the cancer is and how best to treat. Doctors also use a cancer’s stage when talking about survival statistics.

The earliest stage gallbladder cancers are called stage 0 (a very early cancer called carcinoma in situ), and then range from stages I (1) through IV (4). As a rule, the lower the number, the less the cancer has spread. A higher number, such as stage IV, means
cancer has spread more. And within a stage, an earlier letter means a lower stage. Although each person’s cancer experience is unique, cancers with similar stages tend to have a similar outlook and are often treated in much the same way.

Nearly all gallbladder cancers start in the epithelium (the inside wall of the gallbladder). Over time they grow through the various layers toward the outside of the gallbladder. They may also grow to fill some or all the space inside the gallbladder at the same time.

**How is the stage determined?**

The staging system most often used for gallbladder cancer is the American Joint Committee on Cancer (AJCC) **TNM** system, which is based on 3 key pieces of information:

- The extent (size) of the **tumor (T)**: How far has the cancer grown into the wall of the gallbladder? Has the cancer grown through the gallbladder wall into nearby organs such as the liver? The gallbladder wall has several layers. From the inside out, these are: The epithelium, a thin sheet of cells closest to the inside of the gallbladder. The lamina propria, a thin layer of loose connective tissue (the epithelium plus the lamina propria form the mucosa). The muscularis, a layer of muscular tissue that helps the gallbladder contract, squirting its bile into the bile duct. The perimuscular (“around the muscle”) fibrous tissue, another layer of connective tissue. The serosa, the outer covering of the gallbladder that comes from the peritoneum, which is the lining of the abdominal cavity.
- The spread to nearby lymph nodes (N): Has the cancer spread to nearby lymph nodes and if so, how many?
- The spread (metastasis) to distant sites (M): Has the cancer spread to distant organs such as the liver, peritoneum [the lining of the abdominal cavity], or the lungs?

The system described below is the most recent AJCC system effective January 2018. This system is used to stage cancers of the gallbladder as well as cancers that start in the cystic duct (the tube that carries bile away from the gallbladder).

The staging system below uses the pathologic stage (also called the surgical stage) which is determined by examining tissue removed during an operation. Sometimes, if surgery is not possible right away or at all, the cancer will be given a clinical stage instead. This is based on the results of a physical exam, biopsy, and imaging tests. The clinical stage will be used to help plan treatment. Sometimes, though, the cancer has spread further than the clinical stage estimates, and may not predict the patient’s outlook as accurately as a pathologic stage.

Numbers or letters after T, N, and M provide more details about each of these factors. Higher numbers mean the cancer is more advanced. Once a person’s T, N, and M
categories have been determined, this information is combined in a process called *stage grouping* to assign an overall stage. For more information see [Cancer Staging](#).

Cancer staging can be complex, so ask your doctor to explain it to you in a way you understand.

<table>
<thead>
<tr>
<th>AJCC Stage</th>
<th>Stage grouping</th>
<th>Stage description*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Tis N0 M0</td>
<td>Cancer cells are only found in the epithelium (the inner layer of the gallbladder) and have not grown into deeper layers of the gallbladder. This is also known as <em>carcinoma in situ</em> (Tis). It has not spread to nearby lymph nodes (N0) or to distant sites (M0).</td>
</tr>
<tr>
<td>I</td>
<td>T1 N0 M0</td>
<td>The tumor has grown into the lamina propria or the muscle layer (muscularis) (T1). It has not spread to nearby lymph nodes (N0) or to distant sites (M0).</td>
</tr>
<tr>
<td>IIA</td>
<td>T2a N0 M0</td>
<td>The cancer has grown through the muscle layer into the fibrous tissue on the side of the peritoneum (the lining of the abdominal cavity) (T2a). It has not spread to nearby lymph nodes (N0) or to distant sites (M0).</td>
</tr>
<tr>
<td>IIB</td>
<td>T2b N0 M0</td>
<td>The cancer has grown through the muscle layer into the fibrous tissue on the side of the liver without invading the liver (T2b). It has not yet spread to nearby lymph nodes (N0) or to distant sites (M0).</td>
</tr>
<tr>
<td>IIIA</td>
<td>T3 N0 M0</td>
<td>The cancer has grown through the serosa (the outermost covering of the gallbladder) and/or it has grown from the gallbladder directly into the liver and/or a nearby structure such as the stomach, duodenum (first part of the small intestine), colon, pancreas, or bile ducts outside the liver (T3). It has not yet spread to nearby lymph nodes (N0) or to distant sites (M0).</td>
</tr>
<tr>
<td>IIIB</td>
<td>T1-3 N1 M0</td>
<td>The cancer has <em>not</em> grown directly into the liver or nearby organs such as the stomach, duodenum, colon, pancreas or bile ducts (T1 to T3), but it has spread to no more than 3 nearby lymph nodes (N1). It has not spread to distant sites (M0).</td>
</tr>
<tr>
<td>IVA</td>
<td>T4 N0 or N1 M0</td>
<td>The tumor has grown into one of the main blood vessels leading into the liver (portal vein or hepatic artery) or it has grown into 2 or more structures outside of the liver (T4). It has not spread to nearby lymph nodes (N0) or might have spread to no more than 3 nearby lymph nodes (N1). It has not spread to distant sites (M0).</td>
</tr>
<tr>
<td>IVB</td>
<td>Any T N2 M0</td>
<td>The primary tumor may or may not have grown outside the gallbladder. The cancer has spread to 4 or more nearby lymph nodes (N2). It has not spread to distant sites (M0).</td>
</tr>
</tbody>
</table>
The primary tumor may or may not have grown outside the gallbladder. The cancer may or may not have spread to nearby lymph nodes. Cancer has spread to distant sites such as the liver, peritoneum (the lining of the abdominal cavity), or the lungs (M1).

* The following additional categories are not listed on the table above:

  - **TX**: Main tumor cannot be assessed due to lack of information.
  - **T0**: No evidence of a primary tumor.
  - **NX**: Regional lymph nodes cannot be assessed due to lack of information.

### Other Prognostic Factors

Besides your stage, there are other factors that can affect your prognosis (outlook).

#### Grade

The grade describes how closely the cancer looks like normal tissue when seen under a microscope.

The scale used for grading gallbladder cancer is from 1 to 3.

  - Grade 1 (G1) means the cancer looks much like normal gallbladder tissue.
  - Grade 3 (G3) means the cancer looks very abnormal.
  - Grade 2 (G2) falls somewhere in between.

Low-grade cancers (G1) tend to grow and spread more slowly than high-grade (G3) cancers. Most of the time, the outlook is better for Grade 1 and Grade 2 cancers than it is for Grade 3 cancers of the same stage for gallbladder cancer.

#### Subtype

The specific type of gallbladder cancer you have can influence your outlook. Rare cancer types such as squamous and adenosquamous carcinomas of the gallbladder tend to have a worse prognosis (outlook) than adenocarcinomas. Papillary carcinomas tend to have a favorable prognosis.

#### Lymphovascular Invasion

If cancer cells are seen in small blood vessels (vascular) or lymph vessels (lymphatics)
under the microscope, it is called *lymphovascular invasion*. When cancer is growing in these vessels, there is an increased risk that it has spread outside the gallbladder. Gallbladder cancers with lymphovascular invasion tend to have a poor prognosis.

**Extent of Resection**

Whether the entire gallbladder tumor can be removed with surgery can influence your outlook. Cancers that can be removed completely by surgery tend to have a better outlook than those cancers that cannot.

- *Resectable* cancers are those that doctors believe can be removed completely by surgery.
- *Unresectable* cancers have spread too far or are in too difficult a place to be removed entirely by surgery.

Unfortunately, only a small portion of gallbladder cancers are resectable when they are first found.

**References**

See all references for Gallbladder Cancer

Last Medical Review: December 13, 2017 Last Revised: December 13, 2017

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**Survival Statistics for Gallbladder Cancer by Stage**

Survival rates are often used by doctors as a standard way of discussing a person’s prognosis (outlook). Some people may want to know the survival statistics for people in similar situations, while others may not find the numbers helpful, or may even not want to know them. If you decide you don’t want to know them, stop reading here and skip to the next section.

When discussing cancer survival statistics, doctors often use a number called the *5-year survival rate*. The 5-year survival rate refers to the percentage of patients who live
at least 5 years after their cancer is diagnosed. Of course, many of these people live much longer than 5 years, and some people with gallbladder cancer may die from other causes. These survival rates do not take other causes of death into account.

To get 5-year survival rates, doctors have to look at people who were treated at least 5 years ago. Although the numbers below are among the most current we have available, improvements in treatment since then may result in a better outlook for people now being diagnosed with gallbladder cancer.

The rates below are based on the stage of the cancer at the time of diagnosis. When looking at survival rates, it’s important to understand that the statistics may be different for cancers that have come back or progressed during treatment. Still, the stage of a cancer does not change over time, even if the cancer progresses. A cancer that comes back or spreads is still referred to by the stage it was given when it was first found and diagnosed, but more information is added to explain the current extent of the cancer. (And of course, the treatment plan is adjusted based on the change in cancer status.)

The numbers below come from the American College of Surgeons/American Cancer Society National Cancer Data Base as published in the AJCC Cancer Staging Manual in 2010 and are based on more than 10,000 patients diagnosed with gallbladder cancer from 1989 to 1996.

<table>
<thead>
<tr>
<th>Stage</th>
<th>5-Year Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>80%</td>
</tr>
<tr>
<td>I</td>
<td>50%</td>
</tr>
<tr>
<td>II</td>
<td>28%</td>
</tr>
<tr>
<td>IIIA</td>
<td>8%</td>
</tr>
<tr>
<td>IIIB</td>
<td>7%</td>
</tr>
<tr>
<td>IVA</td>
<td>4%</td>
</tr>
<tr>
<td>IVB</td>
<td>2%</td>
</tr>
</tbody>
</table>

Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they can’t predict what will happen with any particular person. Many other factors can also affect a person’s outlook, such as their age and overall health, and how well the cancer responds to treatment. Even when taking these other factors into account, survival rates are at best rough estimates. Your doctor can tell you how the numbers above apply to you, as he or she knows your situation best.

- References

See all references for Gallbladder Cancer

Last Medical Review: October 29, 2014 Last Revised: February 5, 2016
What Should You Ask Your Doctor About Gallbladder Cancer?

It is important to have honest, open discussions with your cancer care team. They want to answer all of your questions, no matter how minor they might seem. For instance, consider these questions:

- Has my cancer spread beyond the gallbladder?
- What is the stage of my cancer, and what does that mean in my case?
- Do I need other tests before we consider treatment options?
- Do I need to see any other kinds of doctors?
- How much experience do you have treating this type of cancer?
- What are my treatment options?
- Can my cancer be removed with surgery?
- What do you recommend and why?
- What is the goal of treatment?
- What risks or side effects are there to the treatments you suggest? How long are they likely to last?
- How quickly do we need to decide on treatment?
- What should I do to be ready for treatment?
- How long will treatment last? What will it be like? Where will it be done?
- How will treatment affect my daily activities?
- What are the chances my cancer can be cured with these treatment plans?
- What would my options be if the treatment doesn’t work or if the cancer comes back?
- What type of follow-up might I need after treatment?

Along with these sample questions, be sure to write down some of your own. For instance, you might want more information about recovery times so you can plan your work or activity schedule. Or you might want to ask about second opinions or about clinical trials for which you may qualify.

Keep in mind that doctors are not the only ones who can provide you with information. Other health care professionals, such as nurses and social workers, may have the
answers to some of your questions. You can find out more about speaking with your health care team in Talking With Your Doctor.

- References
See all references for Gallbladder Cancer

Last Medical Review: October 29, 2014 Last Revised: February 5, 2016

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