A 60 years old female patient presented with pain in the right hypochondriac region, which was colicky and non-radiating and associated with nausea, vomiting and generalised itching for 6 months off and on. There was no significant past history of any major illness. The patient was afebrile, and icterus was present. An ill-defined mass was found in the right hypochondriac region, which was firm, tender and immobile and measured 5 x 4 cm. Routine haematological parameters were within the normal limits. Liver function tests showed bilirubin 8 mg% (direct 6.4 mg%), SGOT was 68 I/U and SGPT 80 I/U. Alkaline phosphatase was 3 times the upper limit of normal. Ultrasonography of abdomen revealed an isoechoic mass in the supraduodenal region. The gall bladder was distended and filled with sludge and microlithiasis and the common bile duct was dilated. Peripancreatic and periportal lymph nodes were enlarged. Computerised tomographic scan of the abdomen showed hepatomegaly with dilated intrahepatic biliary radicles, irregularity and thickening of gall bladder wall. A mass was seen at the neck of gall bladder reaching up to segment IV of liver and compressing the common bile duct. Patient subsequently underwent endoscopic retrograde cholangio-pancreatography which showed filling defect in gall bladder with dilated biliary radicles. A papillotomy was performed and stent was inserted for the biliary drainage. When the patient’s general condition was stabilized an exploratory laparotomy was performed which revealed a mass in the neck of gall bladder measuring 6 cm x 5.5 cm, adherent to common bile duct with multiple satellite nodules in the liver and enlarged draining lymph nodes. Since the mass was unresectable, only multiple biopsies were taken and patient was discharged with the stent in situ. The follow up took 2 to 2 months was uneventful.

Histopathological examination showed moderately differentiated adenocarcinoma with presence of multiple giant cells [Figure 1]. The tumour cells were round with increased nuclear to cytoplasmic ratio and hyperchromatic nuclei and were arranged in glandular pattern. Giant cells were benign, distributed uniformly throughout the tumor. They were multinucleated (number of nuclei ranged from 10 to 40) resembling osteoclast like giant cells. There was no mesenchymal component admixed with the tumor.

**Discussion**

Out of 159 gall bladder carcinomas studied by Albores-Saavedra, 16 cases showed unusual histology of which 7 were giant cell adenocarcinoma. Ito et al have reported well-differentiated carcinoma of the gall bladder containing osteoclast like giant cells exhibiting transitional areas. The same tumour showed metastasis in liver, which was composed chiefly of osteoclast like giant cells with minute carcinomatous element. Our case does not fall into the category of giant cell adenocarcinoma, because all the giant cells appeared to be reactive and benign without any transformation zone or pleomorphism even on studying multiple sections. Grosso and Gonzalez have reported adenosquamous carcinoma of gall bladder with benign stromal osteoclast like giant cells, which is similar to our case. The presence of giant cells with adenocarcinoma has been described as either component of or a reaction to malignant epithelial tumors at various sites. Giant cells in giant cell adenocarcinoma of gall bladder are thought to have mesenchymal origin. Some have been shown to be associated with adenocarcinoma with sarcomatoid features.

Though the tumour in this case was unresectable with distant metastasis, prognosis of well to moderately differentiated adenocarcinomas gall bladder with osteoclast like giant cells has been reported to be less aggressive as compared to giant cell adenocarcinoma.
adenocarcinomas.\textsuperscript{[1,3]} Hence it is important to differentiate two variants of gall bladder carcinoma on histology for the prognostic significance.

References