3.7 Gall bladder and biliary tract

Table 3.7.1
Overview of key epidemiological parameters for Germany, ICD-10 C23 – C24

	2009		2010		Prediction for 2014	
	Men	Women	Men	Women	Men	Women
Incident cases	2,210	3,080	2,240	3,070	2,400	2,700
Crude incidence rate[1]	5.5	7.4	5.6	7.4	6.0	6.6
Standardised incidence rate[1,2]	3.8	3.7	3.8	3.7	3.7	3.0
Median age at diagnosis	72	76	72	76		
Deaths	1,190	2,035	1,234	2,041		
Crude mortality rate[1]	3.0	4.9	3.1	4.9		
Standardised mortality rate[1,2]	2.0	2.3	2.1	2.3		
5-year prevalence	3,600	4,200	3,600	4,200		
Absolute 5-year survival rate (2009-2010)[3]			16 (7-27)	15 (12-19)		
Relative 5-year survival rate (2009-2010)[3]			19 (8-31)	18 (14-23)		

[1] per 100,000 persons [2] age-standardised (European standard) [3] in percentages (lowest and highest value of the included German federal states)

Epidemiology

In Germany, about 5,300 new cases of malignant tumours of the gall bladder (approx. 40 %) and of the biliary tract outside the liver (60 %) were diagnosed in 2010. Women develop gall bladder carcinomas more frequently, whereas tumours in the extra hepatic biliary tracts are diagnosed more frequently in men.

Histologically, the majority of these are adenocarcinomas. Other histological variants such as squamous-cell carcinomas or hybrid forms are rare. As with liver cancer, the risk of developing this type increases steadily with age. The lifetime risk is about 0.6 % for women and 0.5 % for men.

Since 1999 the age-standardised incidence rate in Germany has declined for women and remained largely unchanged for men. However, because of demographic changes the absolute number of new cases has increased significantly among men. The age-standardised mortality rates for the same period have decreased constantly in both genders.

The survival prospects with malignant tumours of the gall bladder and biliary tract are generally poor, yet better than for liver cancer. The relative 5-year survival rate for women is 18 % and 19 % for men. Details with regard to tumour stage at point of diagnosis exist for approximately 50 % of gall bladder cases registered, most of which were diagnosed in stage T2 and T3.

Risk factors and early detection

The triggers for gall bladder carcinomas are not absolutely clear. In the current scientific debate, the presence of gallstones, chronic inflammatory diseases of the biliary tract, such as a primary sclerosing cholangitis (PSC), the inflammatory bowel disease ulcerative colitis, liver diseases as a result of the high consumption of alcohol, hepatitis-C virus infection, and HIV infection are all deemed to be possible risk factors. As lifestyle related risk factors, obesity and smoking are suspected of increasing the risk of biliary tract carcinomas. Diabetes can also increase the risk, however, available studies do not show clearly enough whether this applies for both type 1 and type 2 diabetes. A further risk factor, especially in Asia, is an infection with the parasitic liver flukes Clonorchis sinensis or Opisthorchis viverrini.

Various markers are being tested for their suitability for early detection among persons at risk, however, without any practical consequences. There is no screening programme on offer for the general population. Often, however, early stage diagnosis is made upon removing the gall bladder for other reasons.

Figure 3.7.1a
Age-standardised incidence and mortality rates, by sex, ICD-10 C23 – C24, Germany 1999 – 2010
per 100,000 (European standard)

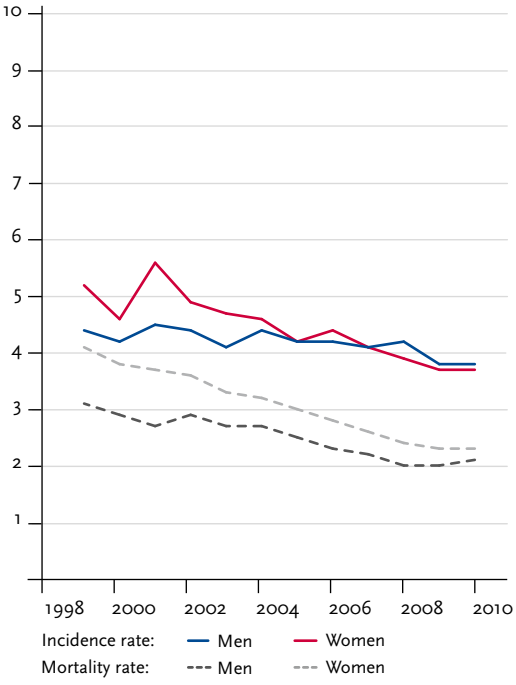


Figure 3.7.1b
Absolute numbers of incident cases and deaths, by sex, ICD-10 C23 – C24, Germany 1999 – 2010

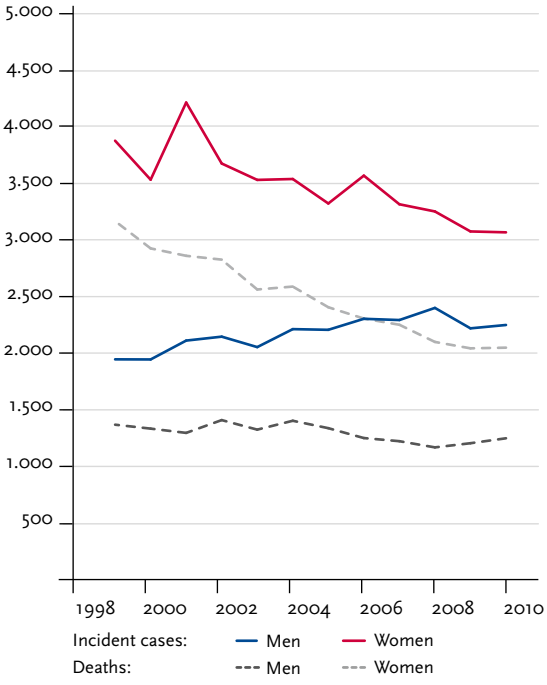


Figure 3.7.2
Age-specific incidence rates by sex, ICD-10 C23 – C24, Germany 2009 – 2010
per 100,000

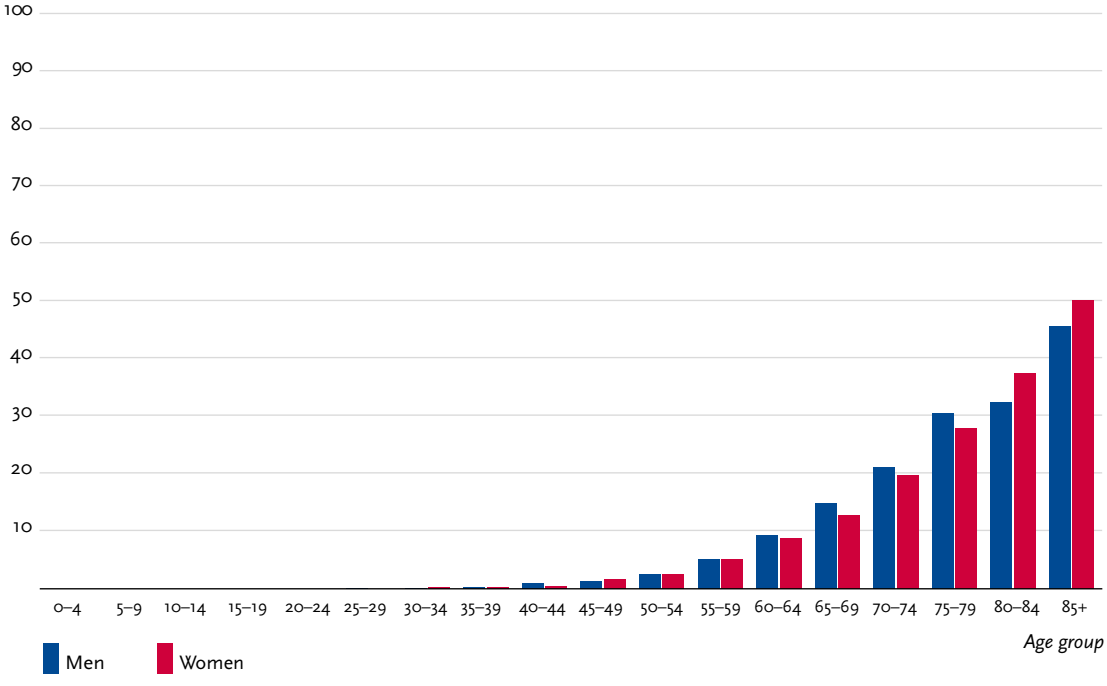


Table 3.7.2
Cancer incidence and mortality risks in Germany by age and sex, ICD-10 C23 – C24, database 2010

	Risk of developing cancer				Mortality risk			
Men aged	**in the next ten years**		**ever**		**in the next ten years**		**ever**	
35 years	<0.1%	(1 in 17,000)	0.5%	(1 in 200)	<0.1%	(1 in 42,000)	0.3%	(1 in 360)
45 years	<0.1%	(1 in 5,000)	0.5%	(1 in 200)	<0.1%	(1 in 9,700)	0.3%	(1 in 360)
55 years	0.1%	(1 in 1,500)	0.5%	(1 in 200)	<0.1%	(1 in 2,900)	0.3%	(1 in 360)
65 years	0.2%	(1 in 640)	0.5%	(1 in 210)	0.1%	(1 in 1,100)	0.3%	(1 in 370)
75 years	0.2%	(1 in 410)	0.4%	(1 in 240)	0.1%	(1 in 720)	0.2%	(1 in 430)
Lifetime risk			0.5%	(1 in 200)			0.3%	(1 in 370)
Women aged	**in the next ten years**		**ever**		**in the next ten years**		**ever**	
35 years	<0.1%	(1 in 26,000)	0.6%	(1 in 160)	<0.1%	(1 in 41,000)	0.4%	(1 in 240)
45 years	<0.1%	(1 in 4,400)	0.6%	(1 in 160)	<0.1%	(1 in 8,400)	0.4%	(1 in 240)
55 years	0.1%	(1 in 1,400)	0.6%	(1 in 160)	<0.1%	(1 in 2,700)	0.4%	(1 in 240)
65 years	0.2%	(1 in 650)	0.6%	(1 in 170)	0.1%	(1 in 1,000)	0.4%	(1 in 250)
75 years	0.3%	(1 in 380)	0.5%	(1 in 210)	0.2%	(1 in 520)	0.3%	(1 in 290)
Lifetime risk			0.6%	(1 in 160)			0.4%	(1 in 240)

Figure 3.7.3
Distribution of T-stages at first diagnosis by sex (top: all cases; bottom: only valid reports)
ICD-10 only C23, Germany 2009 – 2010

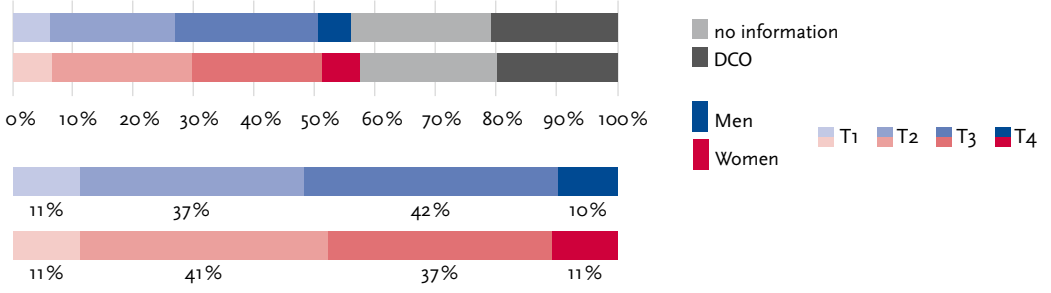


Figure 3.7.4a
Absolute survival rates up to 5 years after first diagnosis, by sex, ICD-10 C23 – C24, Germany 2009 – 2010

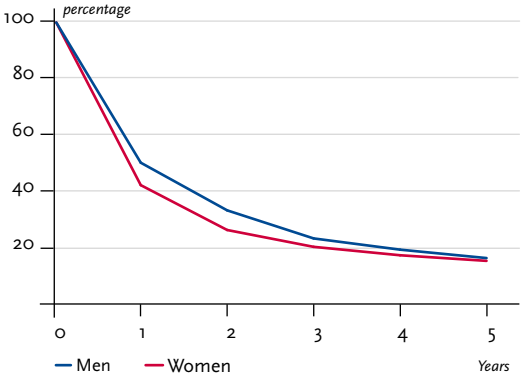


Figure 3.7.4b
Relative survival rates up to 5 years after first diagnosis, by sex, ICD-10 C23 – C24, Germany 2009 – 2010

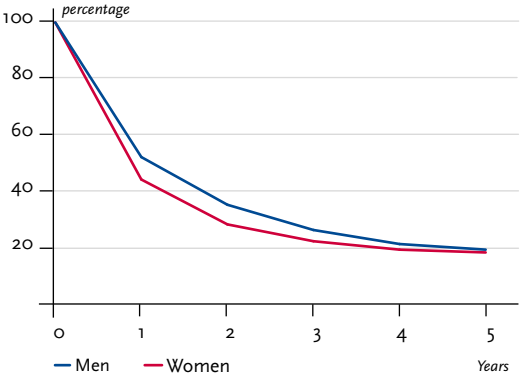


Figure 3.7.5
Registered age-standardised incidence and mortality rates in German federal states, by sex, ICD-10 C23 – C24, 2009 – 2010
per 100,000 (European standard)

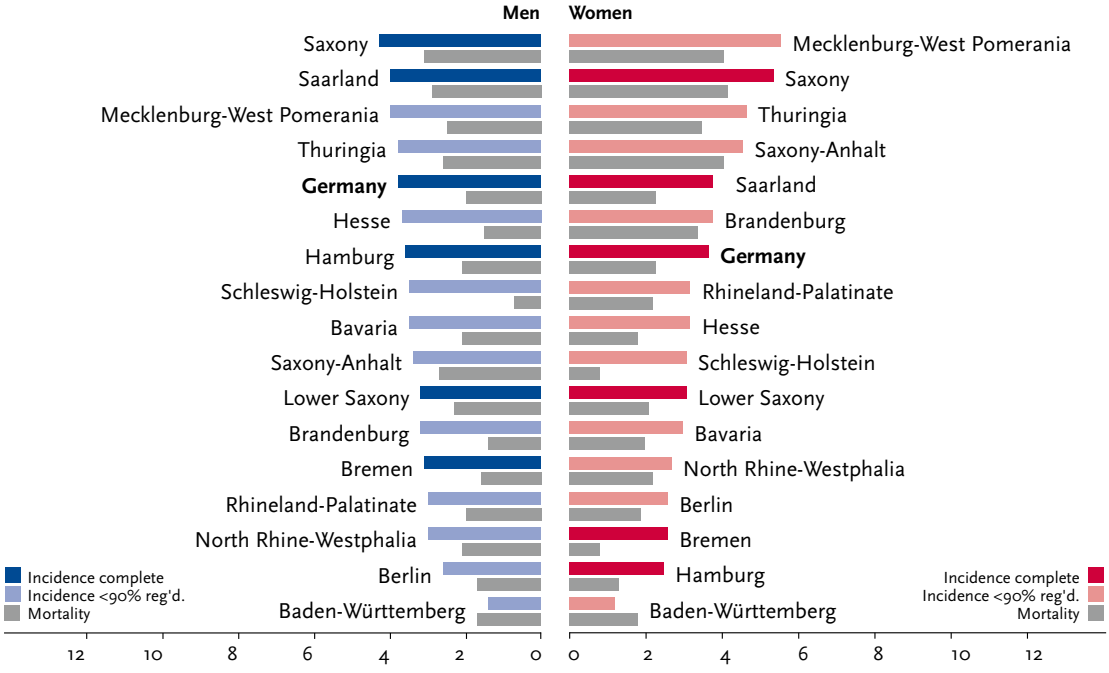
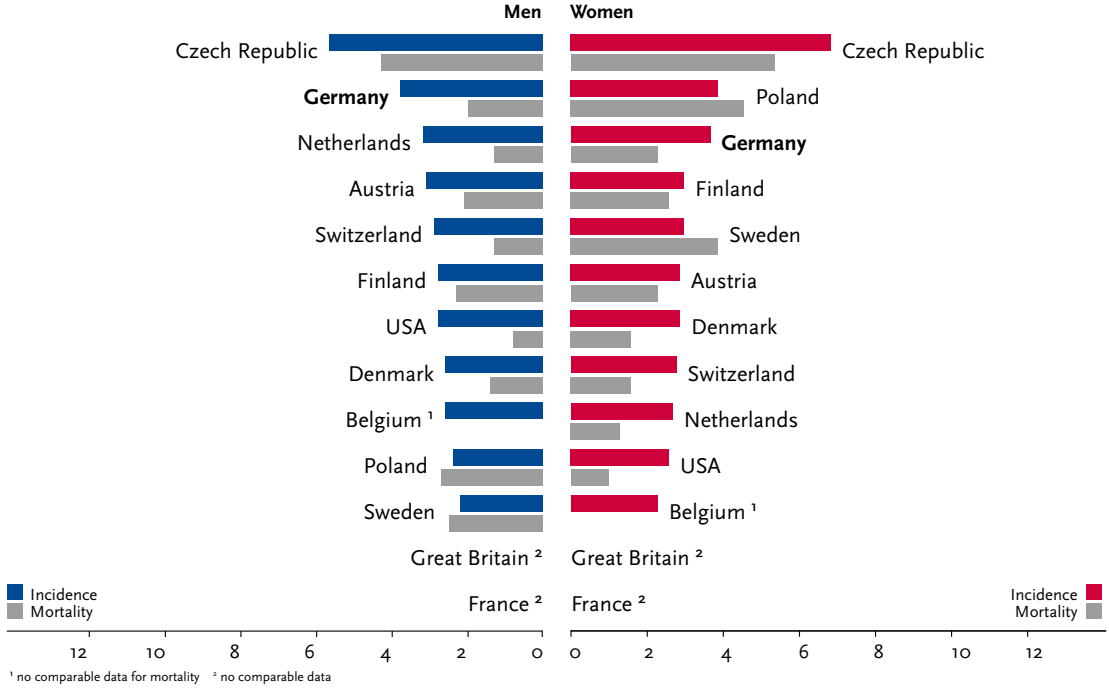


Figure 3.7.6
International comparison of age-standardised incidence and mortality rates, by sex, ICD-10 C23 – C24, 2009 – 2010 or latest available year (details and sources, see appendix)
per 100,000 (European standard)



¹ no comparable data for mortality ² no comparable data