Could This Be
Biliary Tract Cancer (BTC)?

Cholangiocarcinoma Foundation®

Biliary obstruction or cholestatic labs in a patient with biliary tract risk factors warrant early consideration of BTC — a rare and frequently delayed diagnosis. GI / endoscopy is typically the point of first clinical suspicion.

PRESENTING FEATURES
(any 1 or more)

Specific

- ☐ Jaundice, painless or painful
- ☐ Pruritus, often preceding jaundice
- ☐ Dark urine and / or pale stools
- ☐ Right upper quadrant / epigastric pain

Non-specific / asymptomatic

- ☐ Some patients may not present with biliary obstruction
- ☐ Unintentional weight loss
- ☐ Fevers or rigors (ascending cholangitis)
- ☐ Incidental abnormal LFT

RISK FACTORS
(any 1 or more)

- ☐ Primary sclerosing cholangitis (PSC)
- ☐ Longstanding Inflammatory Bowel Disease, diabetes / metabolic syndrome
- ☐ Cirrhosis, chronic viral hepatitis
- ☐ Choledochal cysts / Caroli disease
- ☐ Cholelithiasis (gallstones)
- ☐ Hepatolithiasis, liver fluke exposure

AND/OR

SUPPORTING WORKUP
(any 1 or more)

- ☐ Elevated ALP/GGT +/- bilirubin
- ☐ Serum CA 19-9 elevation
- ☐ Biliary dilation on US/CT without a visualized stone
- ☐ Focal stricture on cross-sectional imaging
- ☐ Indeterminate biliary stricture on prior ERCP

BUT NOT

AGAINST BTC
(none)

- ☐ Stone visualized as clear cause of obstruction
- ☐ Cholestasis resolves fully after stone removal
- ☐ Diffuse, non-focal ductal changes only
- ☐ Alternative diagnosis confirmed on imaging

think BTC | GI is the activation node for the referral pathway

You (GI)
State clearly on referral: ***"Clinical suspicion of biliary tract cancer"***

MRCP/CT
Dedicated imaging defines anatomy and subtype

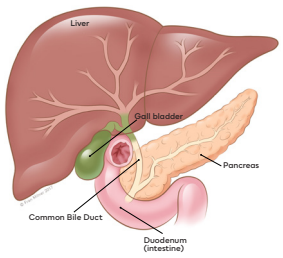
TISSUE
Biopsy/brushings via ERCP, EUS-FNB, percutaneous route

TUMOR BOARD
Multidisciplinary review of staging & resectability

SUBSPECIALTY REFERRAL
HPB surgery / oncology / IR / transplant hepatology as indicated

INTRAHEPATIC CHOLANGIOCARCINOMA (iCCA)
Arises within hepatic parenchyma from intrahepatic bile ducts; often presents as a liver mass rather than obstructive jaundice.
→ Hepatology / IR / surgical onc

DISTAL CHOLANGIOCARCINOMA (dCCA)
Arises in the common bile duct as it courses through the pancreas; can mimic pancreatic head malignancy.
→ Surgical onc / GI / pancreatobiliary



GALLBLADDER CARCINOMA (GBC)
Arises in the gallbladder; often identified at routine cholecystectomy.
→ Surgical onc / GI / pancreatobiliary

PERIHILAR CCA (KLATSKIN) (pCCA)
Arises at the confluence of the right and left hepatic ducts; most common subtype, frequently obstructive at presentation.
→ HPB surgery / transplant onc

THINGS TO CONSIDER DURING WORKUP

01 **Tissue Adequacy, First Pass:** Secure sufficient tissue for histology and biomarker testing during the initial procedure. Repeat biopsies delay treatment and may not be feasible.

02 **Send for Biomarker Testing:** Biomarkers (FGFR2, IDH1, HER2) guide targeted therapy and clinical trials. Send for broad NGS and HER2 IHC with initial pathology rather than waiting for oncology.

03 **Ensure Early Multidisciplinary Input:** Borderline resectability, cirrhosis, or unclear imaging warrant tumor board review. Consider resection or transplant when appropriate.

04 **Connect With Resources:** The Cholangiocarcinoma Foundation offers educational and support resources for patients and care teams.

Scan for more info

or visit curecca.org

11/10/2026