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Case Report

Bladder endometriosis

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Introduction

Endometriosis affecting urinary tract is very rare and constitutes only 1-20% of all cases. It can involve any part of urinary tract with bladder being the most common site (84%)[1]. We report an interesting case of bladder endometriosis in a post-cesarean patient.

Case report

A 32 year old woman $P_2L_1A_1$ presented to our casually on 2nd October, 2004 complaining of severe dysmenorrhea for 1 day duration. Pain started one day prior to her periods with excessive, flow. She had no urinary symptoms.

Her menstrual cycles were regular, but she was complaining of severe dysmenorrhea and menorrhagia since last 4 years. She had one normal delivery. Her second pregnancy ended up in cesarean section at 8 months amenorrhea placenta abruption 14 years back. Eleven months later her last pregnancy ended in $2^1/_2$ months spontaneous complete abortion. She got divorced soon thereafter.

On examination her general condition was fair. Abdominal examination did not reveal any abnormality. Vaginal examination showed a normal cervix and a normal sized uterus. A firm and tender mass of 3x3 cm with restricted mobility was felt anterior to the uterus. The mass was tender.

Ultrasound examination showed a normal uterus and adnexas. An exophytic lesion of 5x5 cm was seen arising from posterior wall of bladder approximately in midline. Cystoscopy was normal except for mild trigonitis. Her blood and urine investigations were within normal limits.

Her pain was not subsiding with simple analgesics. Laparotomy was performed on 13th October, 2004. At laparotomy uterus and adnexa appeared normal. A reddish growth of 5x5 cm with irregular margins was seen arising from posterior wall of the bladder extending upto the dome. The mass was adherent to anterior wall of the uterus at previous cesarean section scar.

Total abdominal hysterectomy was done first after releasing the adhesions and pushing the bladder down. Uterus was removed in view of menorrhagia and dysmenorrhea. Bladder was opened deliberately in

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consultation with urologist who was now called to assist. The mass was seen bulging into the mucosa which was hemorrhagic but had no ulcers. Wide excision of the mass was done with one cm margin and bladder closed in two layers with No. 2 vicryl.

Post operatively the patient recovered well. Foleys catheter was removed on 14th postoperative day and she was discharged on 15th day. Histopathologic study revealed the lesion to be endometriosis.

She was symptom free on first follow up after one month. She never returned for further follow-up.

Discussion

Two distinct forms of bladder endometriosis have been described, spontaneous and post-cesarean type [2,3,5].

Spontaneous type is associated with aggressive locally disseminated disease [2].

Post-cesarean section type occurs secondary to iatrogenic dissemination of endometrial tissue during surgery. Here the lesion remains confined to the bladder and is indistinguishable from a neoplasm [2]. It often presents as reddish blue or blue black nodule on posterior wall of the bladder above the trigone and varies in appearance with phase of menstrual cycle. Its usual size is 0.5 - 1 cm, but it may be as large as 8cm in diameter [2,3]. Though clinical symptoms which correlate with menstrual cycle and cystoscopy aid in diagnosis, histologic proof after laparotomy or laparoscopy [4] is often necessary for diagnosis of post-cesarean type of bladder endometriosis as in our case.

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