

BLADDER ENDOMETRIOSIS

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Case report

A 32-year old woman had recurrent episodes of severe dysuria and lower abdominal pain. Her symptoms recurred despite several courses of urinary antibiotics. She did not have macroscopic haematuria. The physical examination was unremarkable. The urinalysis showed microscopic haematuria and pyuria. The urine culture did not grow any organisms. The abdominal and pelvic ultrasonography was normal. The cystoscopic examination revealed a papillary lesion with bluish patches visible on the surface in the left postero-lateral wall of the bladder. The mucosa was intact over the lesion. Transurethral endoscopic resection of the lesion was done and the histopathology revealed bladder endometriosis (Figures 1, 2 and 3).

Discussion

Endometriosis is a condition in which endometrial tissue, glands or stroma is found outside the normal

limits of the myometrium or uterine cavity. It is most often seen in young women (between 25-35 years of age). Endometriosis affects 5-15% of women in the child-bearing age (1). Endometriosis is commonly seen in the pelvic region, particularly the ovaries and the broad ligament. Urinary tract involvement is uncommon. The bladder is the most common location in the urinary tract accounting for about 80% of urinary tract endometriosis. Involvement of the ureter [15%], kidney [4%] and urethra [2%] are less common (2).

Patients with bladder involvement usually present with micturition syndrome (usually of a cyclical nature), dysuria, increased frequency and urgency. Menuria (haematuria coinciding with the menstrual cycle) is less frequent, occurring in 20% of cases. The endometrial focus infiltrates the bladder from the pericystium towards the mucosa, from outside to inside. In some patients the mucosa is not affected, thus explaining the absence of haematuria (2). The diagnosis is generally confirmed by cystoscopy, biopsy and histopathology. Findings of abdominal ultrasonography are generally non-specific. Treatment consists of resectional surgery (3). The surgical procedures include transurethral endoscopic resection of the lesion or partial cystectomy (open or laparoscopic). Many believe transurethral resection is associated with a high recurrence rate. The management of the endometriosis depends on the severity of the symptoms, the extent of the disease and its location, and the age of the patient and her desire for future fertility.

The macroscopic appearance of the lesions changes with the different phases of the menstrual cycle. During menstruation, the lesions appear more congested and oedematous. If the ectopic tissue does not extend beyond the pericystium cystoscopy is of little use. She is free of a recurrence 6 months after surgery but recurrences may occur many months later.

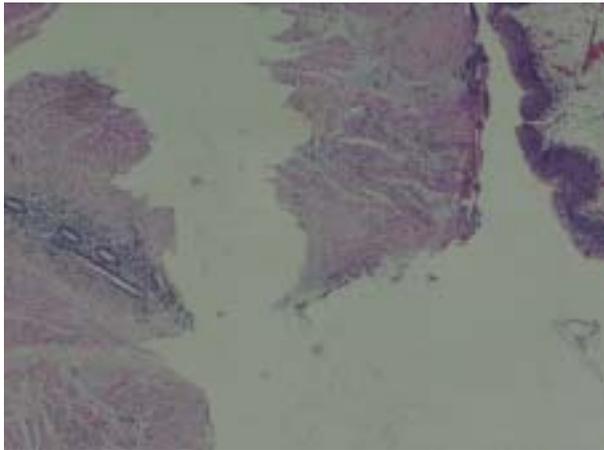


Figure 1. Photomicrograph of H&E stained bladder tissue in (x100).

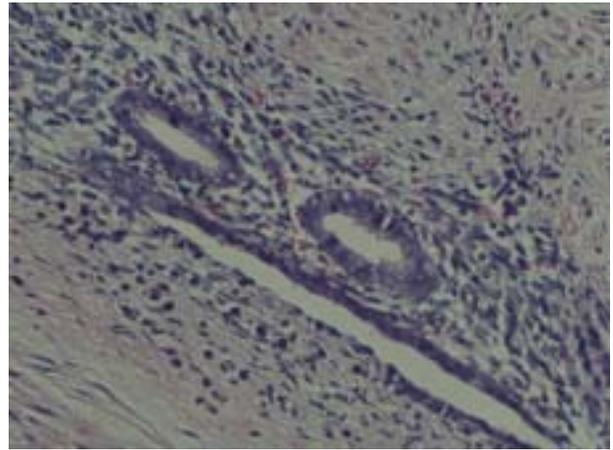


Figure 3. Endometrial tissue with glands surrounded by bladder musculature (x400).

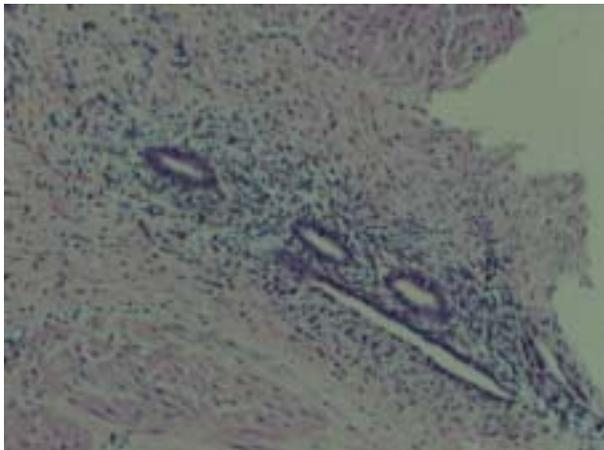


Figure 2. Endometrial tissue with glands surrounded by bladder musculature (x200).

References

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