CASE REPORT

ENDOMETRIOSIS - A CRIPPLING ILLNESS: A RARE CASE OF BLADDER ENDOMETRIOMA

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Endometriosis is a common gynaecological condition affecting 10–12% of general female population. It has variable clinical presentation commonly causing infertility, chronic pelvic pain, and dysmenorrhea. Rare presentation could be a tender cervical/rectal mass therefore should be considered in women of reproductive age group. A 30 years old woman with 1.5 years history of heavy menstrual bleeding with painful menstruation, painful coitus, urinary hesitancy and constipation reported after visiting multiple hospitals and failed medical treatment with pelvic scans showing fibroid uterus. MRI excluded fibroid uterus and laparoscopic exploration of pelvis and subsequent histopathology confirm the mass to be bladder endometrioma.

Keywords: Endometriosis; Female population; Menstrual bleeding; Bladder endometrioma

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INTRODUCTION

Endometriosis is a chronic inflammatory condition characterized by the presence of ectopic functionally active endometrial tissue consisting of glandular epithelium and stroma outside the uterine cavity. Endometriosis affects approximately 176 million women worldwide.[1] The most common sites for disease involvement are ovaries, uterosacral ligaments, pouch of Douglas and rectovaginal septum.[2] Less frequent sites are involvement of cervix, vagina and vulva and is rare in urinary tract, occurring in only 1–2% of women with symptomatic endometriosis and affecting the bladder in most cases.[3] Clinically, the patient may be asymptomatic or show symptoms of menstrual irregularity, pain in the pelvic area, lower abdomen or backache. Ultrasonography could be a useful tool to demonstrate any menstrual associated change in lesion that could aid in establishing a final diagnosis.[4] Due to the paucity of typical urinary tract involvement, we hereby report a usual case of bladder endometriosis.

CASE PRESENTATION

The patient was a 30 years old woman who visited us initially 1.5 year back with complains of heavy menstrual bleeding and post coital bleeding for last 2 months. She was previously evaluated by some general practitioner and was advised pelvic scan which was unremarkable. She then reported again after 6 months with further worsening of her symptoms; her cycles were regular of 21 days and she used to bleed heavily for 8 days with multiple pads soakage. Upon further questioning she used to experience severe pain during menstruation which was worse during first 3 days of cycle and then gradually subsided after taking oral analgesics. She also had painful coitus particularly deep dyspareunia and her inability to conceive. There was no history of inter menstrual bleeding. Her symptoms had aggravated over the past one year with development of urinary hesitancy and occasional dribbling in the last 4–5 months and also complained of constipation. There was no history of dysuria, urinary urgency or frequency or association of dyschezia or cyclical per rectal bleeding. She now had episodes of lower abdominal pain off and on not related to her menstrual cycle as well. She had been receiving symptomatic treatment for her heavy menstrual bleeding as suspected case of fibroid uterus but did not respond to antifibrinolytics and even low dose progesterone.

As part of her obstetrical history, she was nulliparous and have been trying to conceive for the past 1.5 years but no proper treatment was taken. Her past medical history revealed newly diagnosed hypertension besides that she had no medical or surgical risk factors.

There was no personal history or history of contact with tuberculosis. Patient did not have any addiction and was in a monogamous marriage. There was no family history of gynaecological or colorectal malignancy.

Her general physical examination was unremarkable with normal thyroid and all accessible lymph nodes were not palpable. Her abdominal examination did not reveal any palpable mass but tender in the lower abdomen. Per speculum examination could not be performed due to unbearable pain experienced by the patient. Gentle but limited per vaginal and per rectal examination showed tender mass involving cervix

or rectum with initial diagnosis of malignancy however keeping in view that patient did not report per vaginal discharge, per rectal bleeding, significant weight loss or appetite changes, clinical suspicion of endometriosis was made and an MRI pelvic scan was organized.

MRI scan showed slightly enlarged uterus with adenomyosis and an infiltrating mass of 3×4 cm involving dome of bladder and anterior surface of uterus with suspicion of neoplastic lesion. Patient underwent laparoscopic surgical exploration of pelvis. At surgery, frozen pelvis with stage 4 endometriosis was found with adhesions between bladder, uterus and round ligament. A 4×4 cm mass between base of bladder and uterus was found infiltrating the bladder wall. Cystoscopy revealed endometriotic nodules on fundus of bladder (Figure-1), both ovaries were adherent to the pouch of Douglas and both uterosacral ligaments puckered.

Bladder mass was resected (Figure-2) revealing chocolate coloured fluid confirming the diagnosis of endometriosis followed by bladder repair (Figure-3), with definitive histological confirmation on biopsy to be endometrioma.

Patient made an uneventful recovery postoperatively; she was followed after discharge and was advised cystogram after 21 days post-surgery and to induce medical amenorrhea for 6 months by GNRH analogues.

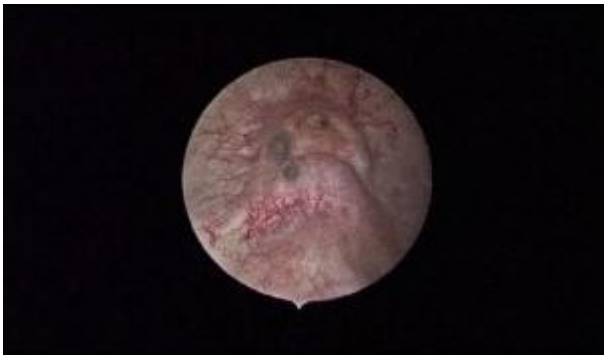

Figure-1: Bladder Endometrioma

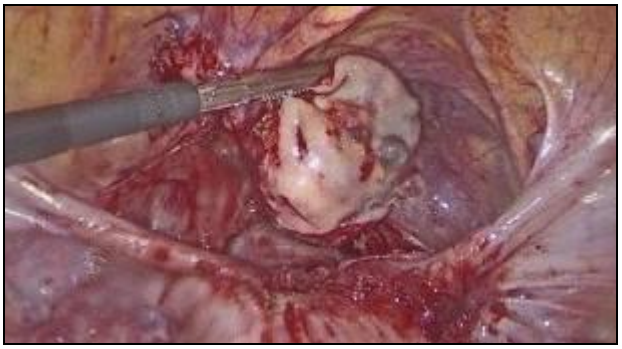

Figure-2: Endometriotic Nodule

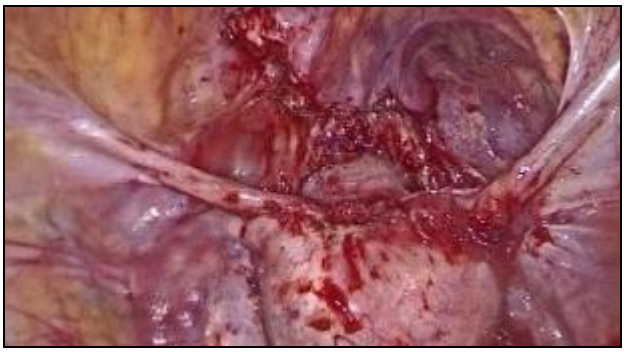

Figure-3: Bladder Repair

DISCUSSION

Endometriosis is the presence of endometrium at a site outside the endometrial lining. The condition was first described by Carl Van Rokinstasy in 1860.[5] It has a multifactorial origin. Various underlying mechanisms have been proposed with retrograde menstruation being the most widely accepted one; other causes could be coelomic metaplasia, hormonal changes, oxidative stress, inflammation and immune dysfunction with genetic predisposition as well.[6] Endometriosis is a disease of reproductive age group with peak incidence in third and fourth decade of life. The ectopic islands of endometrial tissue respond to cyclical hormonal variations typically producing symptoms of dysmenorrhea, dyspareunia and chronic pelvic pain and can lead to primary or secondary infertility as well; as was the case with our patient.[7] In the case of urinary tract involvement, bladder is the most commonly affected organ (84%).[8] Endometriosis has the tendency to produce an array of symptomatic overlap with other abdominopelvic conditions and can produce symptoms and radiological appearances even suggestive of malignancy. Treatment is mainly patient centered with providing hormonal and nonhormonal treatments to provide symptomatic pain relief, clinical disease suppression and improvement in quality of life. Our patient had long standing history of conservative medical therapy that was of unproven benefit and with suspicion of neoplastic lesion, plan for diagnostic laparoscopy followed by cystoscopy was made. Various surgical modalities are in use for bladder endometriosis: transurethral resection, open and laparoscopic partial cystectomy. Endoscopic resection is currently the treatment of choice.

CONCLUSION

Endometriosis has varied clinical presentations with involvement of both intrapelvic and extra pelvic structures. Endometriomas sometimes pose a diagnostic challenge, therefore pertinent history and careful examination should be the key for diagnosis with MRI being the imaging modality of choice.

Bladder endometriosis is a rare entity with its evolution and prognosis been evaluated in small case series, with clinical improvement in most patients.

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