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ENDOSALPINGIOSIS OF THE BLADDER. A CASE REPORT

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Summary.- OBJECTIVE: To describe a case of endosalpingiosis of bladder and review of the literature.

METHOD: A 38 years old women referred to an outpatient urology clinic with postmenstrual voiding symptoms.

RESULTS: We studied her and ultrasound imaging detects tumor that was confirmed by cystoscopy. She is diagnosed of endosalpingiosis of the bladder after transurethral resection, and a CT shows a consistent mass next to left adnexal with high probability of being an endometrioma.

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CONCLUSIONS: Endosalpingiosis of the bladder is a rare disease that occurs in young women with cyclic urinary symptoms. The implantation of tubular tissue in the bladder is diagnosed and treated definitively by tumor excision and anatopathologic examination.

**Keywords:** Endosalpingiosis o bladder. Müllerianosis vesical. Endometriosis. Dysuria postmenstrual. Disuria.

Resumen.- OBJETIVO: Descripción de un caso de endosalpingiosis vesical y revisión de la literatura.

MÉTODO: Mujer de 38 años derivada a consultas de urología con clínica miccional postmenstrual.

RESULTADOS: Se valora en consulta y se detecta en ecografía imagen tumoral que se confirma con cistoscopia. Se diagnostica de endosalpingiosis vesical tras resección tranuretral, objetivándose en TAC posterior masa dependiente de anejos izquierdos compatible con endometrioma.

CONCLUSIONES: La endosalpingiosis vesical es una patología poco frecuente que se presenta en mujeres jóvenes con clínica miccional cíclica. La implantación de tejido tubárico en la vejiga se diagnostica y trata de forma definitiva mediante exéresis de la lesión y estudio anatopatológico.

**Palabras clave:** Endosalpingiosis vesical. Müllerianosis vesical. Endometriosis vesical. Disuria.

INTRODUCTION

The endosalpingiosis of the bladder is the implantation of tubular tissue in bladder (1). There are few cases of isolated endosalpingiosis, it is usually associated with other tissues derived from the müllerian (endometrium and endocervix) (1,2).

We report a case of isolated bladder in a young patient who presented micturition symptoms.

CASE REPORT

38 year-old woman without any interesting medical history previous except for 2 pregnancies and cesarean, who was admitted to our department of urology for dysuria, abdominal pain and vomiting. The genital and abdominal examinations were unremarkable. No Analytical disturbances. After the first consultation we requested her an urine culture, which was negative, and ultrasound test where we could see an suspicious image of bladder cancer. Because these results, we decided making a cystoscopy, and we objectify an exophytic perimetal left mass, with whitish color and glandular appearance that seemed to secret mucus. She was scheduled for doing a transurethral resection of bladder (TUR).

In the pathological examination of the fragments were sparsely glandular formations lined by tubal type epithelium that were located in the thickness of the muscle layers, being reported as “endosalpingiosis” (tubal metaplasia) (Figures 1 and 2).

In subsequent revisions, the patient reported temporary relief of symptoms after resection, which reappeared especially after menstruation. A course of antibiotics were prescribed to her but she did not get any improvement. In control cystoscopy 3 months later, we observed an image similar to the previous one, again in the same location but smaller than the first one, with some calcified parts. A new surgery was performance 4 weeks later, being informed for the pathologist as endosalpingiosis again.

Figure 1. H&E micrography. 4x: transurethral resection: glandular structure within the muscular bladder layers.

Figure 2. H&E micrography. 10x: Tubal glandular epithelium siding, columnar ciliated cells and intercalary cells.
At the same way that after first surgery, the patient got improvement during 2 weeks and after them the symptoms began again, but we did not objectify in cystoscopy any injury to justify her clinic. For that reason, we performed computed tomography (CT) of abdomen with contrast in which we observed left attached inflammatory signs, with a slight thickening and increased uptake of tube and ovary, which shows an increased uptake cyst walls, compatible with endometrioma, accompanied perianadnexal and free fluid in the left side of the Douglas left. These data were submitted for Gynecologist, who performed conservative treatment. Nowadays, the patient is asymptomatic, without signs of recurrence, and late pregnancy is going uneventful.

DISCUSSION

The endosalpingiosis bladder is the presence like tubal tissue like in the bladder (1). This term is purely descriptive, does not imply origin in the uterine tube (2) and may occur separately or more frequently, in combination with other tissues derived from the Mullerian duct (1.2). The presence of mullerian remnants (endometriosis, or endocervicosis endosalpingiosis) alone or in combination is called mullerianosis. There are few reports of isolated endosalpingiosis, probably because they do not usually produce any symptoms (1.3).

Our case is particularly interesting because, despite of being a isolation endosalpingiosis, micturition symptoms were presented, which forced us to study and get the diagnostic results exposed.

The term Mullerianosis was first used by Young and Clemet to describe the discovery of these tissues in three women’s bladder wall (4). Other cases were later reported, always in women in reproductive age. There are two etiopathogenic theories: metaplastic and implanted.

Both are still under discussion (5.6). Young and Clemet proposed implantable origin injury, which is often associated with previous pelvic surgery. Other authors, however, support the metaplastic theory especially in those cases in which previous surgery has not been performance, overall if the lesion is located in posterior face of the bladder and in dome, corresponding with the peritoneal covering bladder (3). Our case further support the implemented theory, in the first place, by a history of previous cesarean section and, secondly, because the location of the lesion was perimeatal, which is not the most common location.

Endosalpingiosis, in most cases is an incidental finding associated with other pelvic diseases. Sometimes, as in our case, it can coexist with endometriosis or imitate it (2), appearing urinary frequency, urgency, dysuria and hematuria related to or exacerbated with menstrual cycle (1). Endosalpingiosis must be considered in cases of chronic pelvic pain (2) but it seems to be an incidental finding associated with pelvic pathology more than being the cause of pain (3).

The best diagnostic test is cystoscopy and biopsy to confirm it (1.6). In the differential diagnosis of mullerianosis, the following entities should be considered:

- “The glandular cystitis”. The glands are cubic or cylindrical stratified epithelium, not ciliate epithelium, that may show lymphocytic infiltrates more or less prominent, and it is associated with Von Brunn nests and it does not affect the muscle wall. Cystitis glandularis of intestinal type is positive for cytokeratin 20 and negative for hormone receptors (7).

- “The nephrogenic adenoma or nephrogenic metaplasia”. It, like the mullerianosis, usually has a history of previous surgery, but it it forms a tubulo papillary structures lined by a single layer of cuboidal epithelium, lacking ciliated mucinous cells. It usually respects the muscular layers of the bladder (7).

The main treatment is surgical excision. TUR results are not completely satisfactory because it exist a high risk of perforation when the lesion is resected because the depth that usually presents and the high rate of recurrence if it is not completely removed. The best technique is laparoscopic or laparotomy resection (1). In our case, we chose transurethral resection because the locate allowed a deep and total resection, although it not achieved at the first time (as a relapse), it was achieved with the second one.

Hormonal therapy with gonadotropin analogs has been used with different results, but it seems to have no clear beneficial effects (9,10). Furthermore, in our case, the patient wished to have children, so we rejected the use of hormonal therapy.

This type of injury (that relapse frequently) should be followed up with cystoscopy and renal and pelvic ultrasound (8,10), although the follow-up duration is not clearly defined (10) because there are not long series of cases that help determine it. In addition, it is also advisable to follow it up because of the possibility of malignancy especially when it is associated with endometriosis (endometrial carcinoma) (5,6,10).

CONCLUSIONS

Endosalpingiosis of the bladder is a rare disease that occurs in young women with cyclic urinary symptoms. The implantation of tubular tissue in the bladder is diagnosed and treated definitively by tumor excision and anatomopathologic examination.
REFERENCES AND RECOMMENDED READINGS
(*of special interest, **of outstanding interest)


URACHAL ADENOCARCINOMA TREATED WITH ROBOTIC ASSISTED LAPAROSCOPY PARTIAL CYSTECTOMY


Summary.- OBJECTIVE: To describe a case of urachal adenocarcinoma treated with robotic assisted laparoscopic partial cystectomy and en-bloc exeresis of urachus and umbilicus and bibliographic review.

METHODS: A 63 year-old man with hematuria and hypogastric pain. He was diagnosed of urachal adenocarcinoma by transurethral resection and axial tomography. We performed a robotic assisted laparoscopic partial cystectomy using a da Vinci® S HD (Intuitive Surgical System) device. We describe the surgical technique and examine total length of time for surgery and for console.