Case Report / Olgu Sunumu

A rare cause of hematuria, intravesical ectopic pregnancy; case report

Hematürinin nadir bir nedeni intravezikal ektopik gebelik; olgu sunumu

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Özet

İntravezikal ektopik gebelik çok nadir görülen bir durumdur. Hastalar geleneksel ektopik gebeliklerden farklı olarak genellikle hematüri ile başvururlar.

Olgumuz 22 yaşında olup karın ağrısı ve idrarda kanama şikayeti ile başvurdu. Fizik muayenede abdominal hassasiyeti gözlendi. ß-HCG 10033 IU/ml olarak ölçüldü. Ultrasonografide vezikouterin fistül traktı ve mesanede dış gebelik kesesi ile uyumlu görünüm izlendi. Sistoskopide mesane sağ yan ile posterior duvar birleşiminde fistül traktı ostiumu ve ektopik gebelik kesesi ile uyumlu kitle görüldü. Gözlenen yapı rezeke edildi ve koterize edilerek hemostaz sağlandı. Takiplerinde komplikasyon gözlenmeyen hasta eksterne edildi. Pelvik cerrahi öyküsü olan, adet gecikmesi ve hematüri şikâyeti ile başvuran hastalarda ayırıcı tanıda ektopik gebelik akılda tutulması gereken tanılardan biri olmalıdır.

Anahtar Kelimeler: vezikal gebelik, vezikouterin fistül, hematüri

Abstract

Intravesical ectopic pregnancy is a very rare condition. Unlike traditional ectopic pregnancies, patients generally present with hematuria.

Our case presented with abdominal pain and urinary bleeding. Abdominal tenderness was observed on physical examination. The ß-HCG was measured as 10033 IU / ml. In ultrasonography, an appearance compatible with a vesicouterine fistula tract and an ectopic gestational sac in the bladder were observed. In cystoscopy, a mass compatible with a fistula tract ostium and ectopic gestational sac was observed at the junction of the right side of the bladder and the posterior wall. The observed structure was resected and cauterized to achieve hemostasis. No complications were observed during the follow-up, and the patient was discharged.

Ectopic pregnancy should be one of the differential diagnoses of patients with a history of pelvic surgery who present with complaints of menstrual delay and hematuria.

Keywords: vesical pregnancy, vesicouterine fistula, hematuria

The article has been presented as an online oral presentation 14. National Endourology Congress on 1-4 April 2021.

INTRODUCTION

Ectopic pregnancy is defined as the implantation of the developing blastocyst outside the uterine cavity (1). The diagnosis is usually made in the first trimester. Although the use of ultrasonography is the first option for diagnosis, serum ß-human chorionic gonadotropin (ß-HCG) and progesterone measurements may also be helpful (2). Although the clinical findings of the disease vary according to the location of the ectopic pregnancy, it can generally be identified by vaginal bleeding, pelvic pain, and abdominal pain (3). However, it is not always easy to diagnose an ectopic pregnancy.

The aim of this presentation is; to present the clinical findings, diagnostic methods and treatment modalities of an intravesical ectopic pregnancy patient presenting with the complaints of menstrual delay, abdominal pain and hematuria.

CASE REPORT

A 22-year-old patient was admitted to the emergency department with complaints of abdominal pain and profuse urinary bleeding. It was learned from the anamnesis of the patient that she had a 15-day delay in menstruation and had three previous caesarean sections. It was also learned that she had occasional urinary bleeding after her last birth, but she never went to the hospital. While abdominal tenderness was observed in the physical examination of the patient, defense and rebound were not detected. No abnormal results were found except for ß-HCG 10033 IU / ml in laboratory tests and erythrocyte 100 / HPF in complete urinalysis. In the ultrasonography, free fluid in the uterine cavity, an appearance compatible with a fistula tract between the uterus and the bladder, an irregular appearance and a hematoma compatible with an ectopic gestational sac of approximately 21*29 mm in the bladder were observed. Emergency cystoscopy and necessary intervention were planned after obtaining informed consent from the patient. Therefore, no additional imaging was performed. In the cystoscopic examination, a mass compatible with the fistula tract ostium and ectopic gestational sac was observed at the junction of the right lateral wall of the bladder and the posterior wall. The pouch was resected with the help of a resectoscope. Hemostasis was achieved by cauterizing the bleeding areas (Figure 1). Then, liquid was aspirated in the uterine cavity with an injector by the gynecologist. Catheterized with a 3-way Foley and bladder was continuously irrigated. Since hematuria was not observed on the postoperative 1st day, bladder irrigation was terminated. The patient, who did not experience any problems in the postoperative follow-up, was discharged on the 2nd postoperative day with a Foley catheter. The Foley catheter was removed 14 days later. Symptoms such as urinary incontinence or hematuria were not observed. The diagnosis was confirmed as an ectopic pregnancy as a result of pathology examination of the materials taken. It was thought that the fistula tract might have closed with conservative treatment. Despite this, cystoscopy and, if necessary, additional intervention were planned. However, control cystoscopy approximately 2 months later was evaluated as normal.

DISCUSSION

Ectopic pregnancy is a devastating clinical condition that can cause significant morbidity and mortality when undiagnosed. Early diagnosis of the disease is extremely important in terms of preserving fertility (4). However, the main problems encountered in diagnosis are the variance in symptoms in each patient and that the symptoms are not specific to the disease. In our case report, an ectopic pregnancy caused by an uterovesical fistula secondary to previous caesarean section is presented. In this intravesically located ectopic pregnancy, unlike traditional ectopic pregnancy types, the main complaint of the patient was hematuria.

Vesicouterine fistulas are a rare condition and constitute approximately 1-4% of urogenital fistulas. Its incidence increases in cases of multiple caesarean section (5). In addition, placenta percreta, endometriosis can also be seen after vaginal delivery after previous caesarean delivery (6). Patients may present with symptoms of cyclic hematuria, amenorrhea, urine discharge from the vagina, urinary incontinence, and abortus in the first period (7). In the diagnosis, ultrasonography and cystoscopy can be performed initially, and if necessary, cystography, intravenous pyelography and magnetic resonance imaging can be performed (8). We observed that our case was in the early pregnancy period of sev-

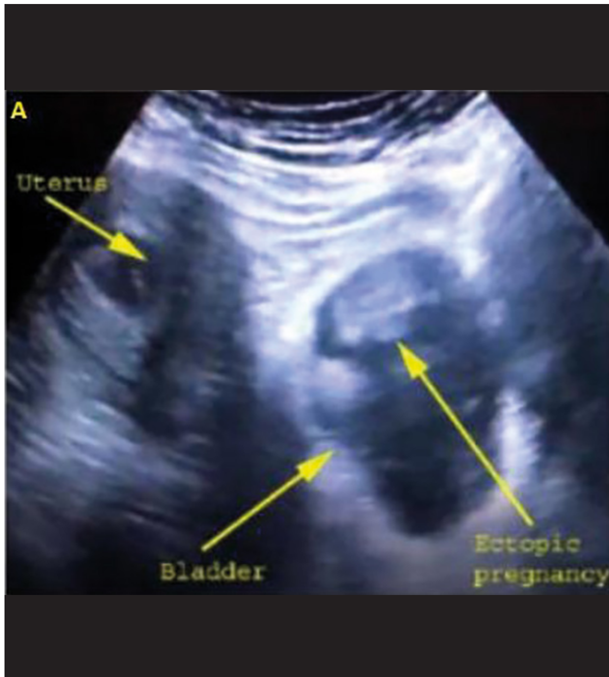

Figure 1.A: Ultrasonographic view of intravesical ectopic gestational sac.

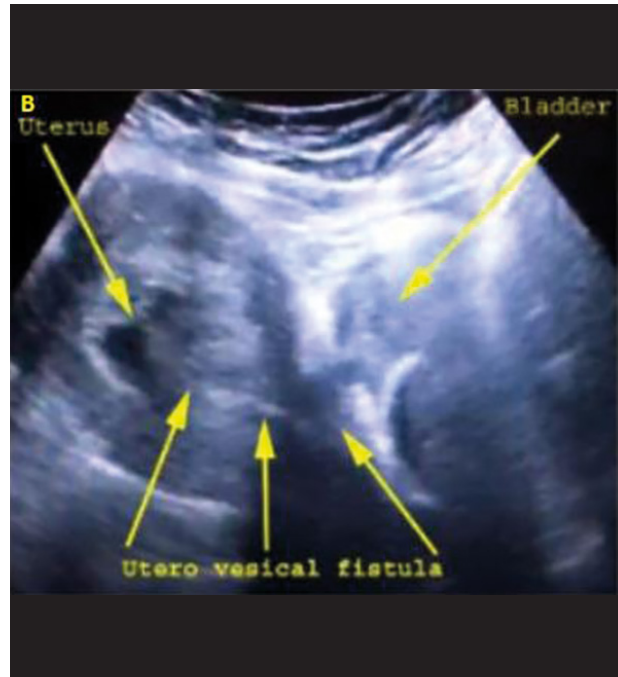

Figure 1.B: Ultrasogographic view of the uterovesical fistula tract.

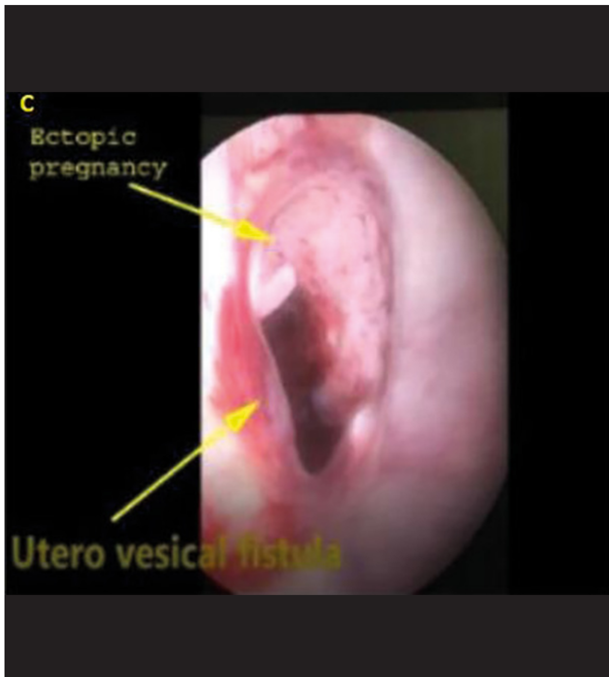

Figure 1.C: Cytoscopic view of the intravesical ectopic gestational sac.

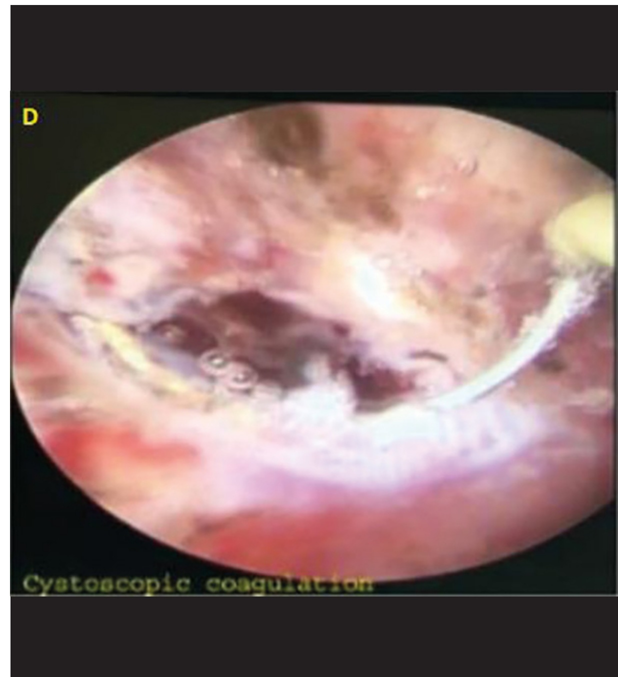

Figure 1.D: Resection of the intravesical ectopic gestational sac and coagulation of the uterovesical fistula tract.

eral weeks. In a study by Armstrong et al. intravesical ectopic pregnancies can also be seen in later weeks, such as the 20-weeks-case (9).

Early intervention is required as soon as vesicouterine fistulas are diagnosed. However, there are also studies suggesting that spontaneous fistulas may close spontaneously and surgical intervention may be delayed for several months (8). In addition, in a study by Jóźwik, it was evaluated that there were many cases that closed spontaneously with bladder drainage or hormonal therapy (10). We also managed our case in a similar way and observed that it was closed spontaneously.

CONCLUSION

As a conclusion, ectopic pregnancy should be one of the diagnoses that should be kept in mind in the differential diagnosis of patients with a history of pelvic surgery who present with complaints of menstrual delay and hematuria.

Acknowledgement

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Conflict of Interest

All authors declared that there is no conflict of interest.

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Author Contributions

Conception and design; AT, Aİ, Data acquisition; AT, ESP, Data analysis and interpretation; MD, İY, Drafting the manuscript; AT, BK, HÇ, Critical revision of the manuscript for scientific and factual content; ESP, BK, Statistical Analysis; Aİ, MD, Supervision; İY, HÇ.

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