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Successful Treatment of Symptomatic Cystitis Glandularis Presenting as Bladder Mass, with COX-2 Inhibitor: A Case Report

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Podium #133

ENDOSCOPIC MANAGEMENT OF A BLADDER PERFORATION FROM A RECTUS SHEATH HEMATOMA

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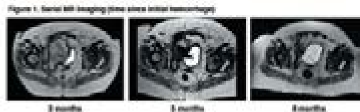
Presented By: Anna Faris

Introduction: Rare reports have described bladder perforation from external hemorrhage sources including retroperitoneal and anterior abdominal wall vasculature. In the unstable patient with hematuria, such individuals can require emergent arterial embolization or open surgical repair of the bladder wall. We present a delayed presentation managed endoscopically.
Case: A 48-year-old female hospitalized with septic ascending cholangitis developed a spontaneous rectal sheath and pelvic hematoma. During her hospitalization she was anuric requiring dialysis and the hematoma became infected requiring long-term antibiotics. Three months after hospitalization she presented to our institution with continued gross hematuria, and severe lower urinary tract symptoms. The extravesicular hematoma was found to have eroded through the bladder wall, likely due to pressure necrosis. Her case was monitored with serial magnetic resonance (MR) imaging and managed with two endoscopic clot resections which demonstrated epithelialization of the bladder wall beyond the hematoma point of entry. After second transurethral resection (TUR) her urinary symptoms completely resolved.
Conclusions: Some patients with pelvic hematomas may develop delayed bladder perforation. We propose that select cases can be managed conservatively with serial imaging and TUR for symptom control as the bladder mucosa may re-epithelialize spontaneously.
Figure 1. Serial MR imaging of bladder hematoma (time since initial hemorrhage).



Funding: N/A

Podium #134

SUCCESSFUL TREATMENT OF SYMPTOMATIC CYSTITIS GLANDULARIS PRESENTING AS BLADDER MASS, WITH COX-2 INHIBITOR: A CASE REPORT

Bilal Muhammad, Resident, Kenneth Peters, Urology Chairman
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Presented By: Bilal Muhammad

Introduction: Cystitis Glandularis is a known proliferative disorder of the urinary bladder. It is the process of glandular metaplasia of transitional cells in the bladder. It often occurs in the setting of chronic irritation of the bladder mucosa. The role of Cystitis Glandularis in a neoplastic process is still unclear, however it has been hypothesized to represent a pre-malignant lesion. Although typically asymptomatic in nature, clinical features of this disorder include recurrent urinary tract infections and lower urinary tract symptoms. Refractory cases can often be hard to treat, at times necessitating total or partial cystectomy. Here we present a case of recurrent symptomatic Cystitis Glandularis in a male patient, and its successful treatment with COX-2 inhibitor.
Case Presentation: 36 year old African-American male presented to clinic with complaints of intermittent dysuria and suprapubic pain with bladder filling. Office cystoscopy demonstrated hypervascular nodular tumors present on multiple sites in the bladder. Patient underwent a transurethral resection of these lesions, with pathology demonstrating Cystitis Glandularis. Subsequent to this the patient re-developed irritative lower urinary tract symptoms and hematuria, and followup cystoscopy demonstrating new lesions. He was started on Celecoxib 100 mg daily, with resultant resolution of his symptoms. Repeat cystoscopy demonstrated mild erythematous lesions, but no new bladder masses.

Discussion: Symptomatic Cystitis Glandularis can present a clinical challenge for the practicing urologist. The disorder is often resistant to antibiotics, anti-inflammatories, and recurrent resection. COX-2 inhibitors provide a safe and effective treatment option, sparing many patients from more aggressive therapies or interventions.

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Podium #135

KNOT YOUR TYPICAL FOREIGN BODY; A CASE REPORT OF COMPLEX FOREIGN BODY REMOVAL

Seth Thomas, DO[1], Eric McKeever, DO[1], Zachary Brennan, OMS[2], Taylor Casey, OMS[2], Elizabeth Deming, OMS[2], Colton Prudnick, DO[3], William Zimmerman, DO[3]

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Presented By: Seth Thomas, DO

Introduction: We present the case of a 60-year-old man who had self-inserted, what he reported was a 2-3 foot piece of plastic tubing into his urethra for relief of urinary symptoms. Bedside removal of the tubing was unsuccessful and the patient required complex surgical extraction in the operating room.

Methods: A PubMed search was conducted using terms related to “urethral foreign body” and “urethral foreign body removal.”

Results: A CT scan in the ED revealed a tubular structure along the lower urinary tract with a complex knot in the bladder lumen. Bedside removal with manual traction was unsuccessful. The patient was then taken to the operating room and required suprapubic cystotomy and Amplatz sheath placement in conjunction with cystoscopy and laparoscopic scissors to remove the foreign body in its entirety. The foreign body was durable plastic tubing measuring 67 inches in length and 5mm in diameter. The suprapubic cystotomy was closed primarily and a foley catheter was left in place.

Conclusion: In such a case of complex foreign body insertion, the urologist may have to employ a creative approach for safe and efficient removal. We present a novel technique for removal of knotted plastic tubing within the bladder, not previously described in literature.

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