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EOSINOPHILIC CYSTITIS MASQUERADING AS CARCINOMA URINARY BLADDER : A CASE REPORT

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ABSTRACT Eosinophilic cystitis is a rare entity that usually presents with hematuria and suprapubic pain and can have the gross appearance of a bladder malignancy. Here we describe a case report of a patient that presented with sub acute intestinal obstruction with the gross appearance of a bladder malignancy invading the sigmoid and was later found to have eosinophilic cystitis.

KEYWORDS : Eosinophilic Cystitis, Sub Acute Intestinal Obstruction, Case report

INTRODUCTION:

Eosinophilic cystitis is a rare inflammatory bladder disorder characterized with transmural inflammation and fibrosis. Here we describe a case of eosinophilic cystitis which presented with sub-acute intestinal obstruction, was operated in the emergency setting with gross picture of an aggressive bladder tumor invading into the recto-sigmoid junction. Histopathological examination later revealed presence of eosinophils in the specimens received from both the bladder and the colon. Although rare in its occurrence but eosinophilic cystitis can masquerade an aggressive bladder tumor.

Case Report:

A 65 years old man presented to the surgical emergency of PGIMS, Rohtak with history of non-passage of flatus and stools, vomiting and progressive distension of abdomen since a duration of 5 days.

There was no history of any previous surgical operations, active pulmonary TB, intake of Anti-tubercular drugs, weight loss effort intolerance, breathlessness, lumps in the abdomen or any urinary complaints as such, no concurrent medical illnesses were present.

Examination revealed a gaseous abdomen with an empty rectum with no palpable lumps along with generalized signs of dehydration.

X-rays revealed dilated bowel loops with air fluid levels. Patient was then taken for surgery. General anesthesia was given and a generous midline incision was made. Intra operative findings were of an edematous hard fundus of the urinary bladder adherent with the rectosigmoid junction, proximal to which the entire large and small bowel were distended with gas and intestinal content with edema of their walls.

An end colostomy was made for diverting feces. A Monks-Moynihan bowel decompression procedure was done. Histopathological examination of both the bladder and the involved large bowel was taken, foley's catheter and drains were placed. Patient recovered from general anesthesia and was transferred to the surgical ward where he made an otherwise uneventful recovery.

A follow up of the histopathological examination of urinary bladder growth biopsy revealed dense fibro collagenous fibroadipose and fibromuscular tissue densely infiltrated by chronic inflammatory cells comprising of lymphocytes, plasma cells, histiocytes, numerous eosinophils along with areas of fibrosis with no evidence of any bladder malignancy. Sections from the colon revealed denudation of mucosa , dense transmural mixed infiltrate comprising of predominantly eosinophils and lymphocytes along with histiocytes and areas of fibrosis, inflammatory exudates and granulation tissue on the serosal aspect favoring eosinophilic colitis.

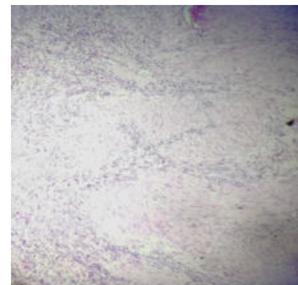


Figure 1a H&E 100X low power

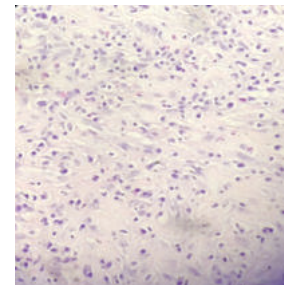
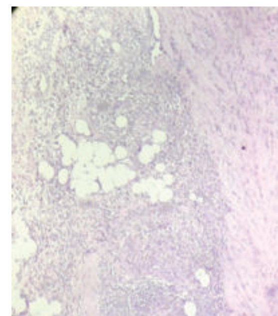
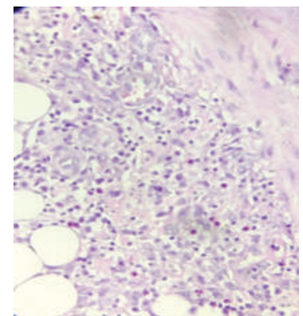


Figure 1b H&E 400X high power

Photomicrograph of urinary bladder growth histopathological examination showing infiltration by eosinophils along with lymphocytes, plasma cells and histiocytes.



H&E 100x low power



H&E 400x high power

Photomicrographs of colonic wall growth showing dense transmural mixed inflammatory infiltration by eosinophils , lymphocytes, neutrophils and histiocytes

DISCUSSION

Eosinophilic cystitis in itself is a relatively rare condition seen mostly after bladder injuries, allergic diathesis, allergic gastro-enteritis, asthma, drug intake.[1] Presentation of the

same can be frequency (67%), dysuria (62%), gross/ microscopic hematuria. (68%), suprapubic pain (49%) and urinary retention (10%).[2]

Investigations in the form of a CT-KUB may demonstrate a filling defect in the bladder and a cystoscopy may reveal a mass lesion which on histopathological examination may reveal the true underlying pathology.[3]

Treatment of the underlying condition consists of resection of the lesion and treatment with antihistaminic, corticosteroids and antibiotics as well as removal of possible allergens.[4] Azathioprine and cyclosporine are reserved for refractory cases.[5] Partial cystectomy may also be done for lesions that do not resolve and are circumscribed.[6]

In our case, the patient presented with the clinical presentation of sub acute intestinal obstruction with no history whatsoever that may suggest a bladder lesion or eosinophilic cystitis as such, and on laparotomy was found to have a growth arising out of the bladder that was involving the rectosigmoid junction which required a fecal diversion in the form of a end colostomy. Diagnosis was reached through a histopathological examination. And patient was discharged on antihistamines along with regular monthly cystoscopy for evaluation of the bladder.

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