**Bladder Endometriosis in Perimenopausal Woman- A Rare Case Report**

Ramya Vandanasetti*, Sirisha Sunkavalli, Tripura Sundari, Uma Devi
Krishna Institute of Medical Sciences, Secunderabad, Telangana, India

**Citation:** Ramya Vandanasetti, Sirisha Sunkavalli, Tripura Sundari, Uma Devi. Bladder Endometriosis in Perimenopausal Woman- A Rare Case Report. ERWEJ. 2023;3(3):98-102. 10.54136/ERWEJ-0303-10057

© Author(s), 2023, Publisher and License: THB. Open Access. This article is distributed under the terms of the Creative Commons Attribution 4.0 International License, which permits unrestricted use, distribution, and non-commercial reproduction in any medium, provided you give appropriate credit to the original author(s) and the source.

*Corresponding Author: Ramya Vandanasetti, Krishna Institute of Medical Sciences, Secunderabad, Telangana, India.
E-mail: ramyalucky123@gmail.com

**Keywords:** Endometriosis; Perimenopausal Woman; Menstrual Cycle; Bladder Endometriosis

**Abstract**

Endometriosis is a gynaecological disease. It is caused by the presence of the endometrial tissue exterior of the uterus. A 45-year-old woman presented with recurrent episodes of dysuria. Computed tomography (CT) scan showed ill-defined mildly enhancing soft tissue density within the vesicouterine region showing loss of fat planes with the posterior wall of the urinary bladder in the region of the trigone s/o bladder endometriosis. The patient was planned for cystoscopy and cystoscopy resection of bladder endometriosis. Endometrioma was resected using a resectoscope. Bilateral ureteric reflexes were elicited, and the rest of the bladder mucosa was normal.

Effective treatment of bladder and urethral endometriosis is best done in collaboration with a team of doctors familiar with endometriosis, such as a gynaecological, radiologist, and urologist.

**Introduction**

Endometriosis is a gynaecological disease. It is caused by the presence of the endometrial tissue exterior of the uterus [1]. Endometriosis is known to affect internal organs such as the ovaries, uterosacral ligament, fallopian tubes, pouch of doglous, and rectum. Sometimes the ureter becomes stenosed by the increase of the surrounding endometriotic tissue [2].

However, the bladder is a rare site for endometriosis. It is estimated that urinary tract endometriosis affects up to 1% of women with pelvic endometriosis (most commonly bladder endometriosis), but its prevalence is as high as 20-50% for women with deep infiltrating endometriosis. The prevalence of disease at specific sites among women with Urinary tract endometriosis (UTE) is as follows: bladder 85%, ureter 10%, kidney 4%, and urethra 2%. Three points explain the origin of bladder endometriosis: a) It consists of remnants of the Müllerian ducts in the

---

98

Content is available online at [https://erwejournal.com/](https://erwejournal.com/)
vesicouterine/vesicovaginal septum, the spread of endometrium-derived stem/progenitor cells and altered genetic/epigenetic or immune factors. b) It is in fact an extension of the adenomyotic nodule of the anterior uterine wall into the bladder c) can be iatrogenic and more prevalent among women with previous cesarean section [3].

Case presentation

A 45-year-old woman, para 2 living 2 (P2L2) with 2 previous lower segment cesarean sections (LSCS), presented with recurrent episodes of dysuria and urgency for 3 years. Dysuria is co-related with menstrual cycles and aggravates after the menses. She also complained of severe dysmenorrhea for 3 years and menstrual haematuria in the last 3 months. Took medical treatment for dysuria but was not relieved.

On evaluation in the clinic, she was conscious and coherent. Thin built: P/A- soft, supra pubic transverse scar +, P/S-cervix vagina healthy, P/V- uterus anteverted, NS, M, FF.

Investigations

The transvaginal sonography (TVS) showed echoic space-occupying lesion (SOL) in the posterior wall of the bladder of 3.2×1.3×2.4 cm. Uterus size and bilateral ovaries were found normal. CT scan showed ill-defined mildly enhancing soft tissue density within the vesicouterine region showing loss of fat planes with the posterior wall of the urinary bladder in the region of the trigone s/o bladder endometriosis. Bulky uterus, B/L ovaries were normal. She was planned for cystoscopy and cystoscopy resection of bladder endometriosis.

Cystoscopy findings

Urethra was normal. A 5×4 cm endometriotic nodule was seen on the posterior wall of the bladder well away from both the ureteric openings. Endometrioma was resected using a resectoscope. Bilateral ureteric reflexes were elicited, and the rest of the bladder mucosa was normal (Figure 1).

Figure 1: Cystoscopy findings a) Endometriotic nodule in the bladder, b) Chocolate fluid aspirated from the nodule
Figure 2: Bladder after removal of endometrioma

Figure 3: Histopathology report

Postoperative management

The patient was given a 3.75 mg Leuprolide acetate injection before discharge. She started on Tab. Dienogest 2 mg. USG was repeated after 2 months and showed no focus on endometriosis in the bladder. Symptoms of dysuria, and menstrual haematuria decreased. She was advised to continue Dienogest.

Discussion

In general, there are two causes of bladder endometriosis: primary and secondary. The report is a result of a deep infiltrating pelvic endometriosis. The second form is iatrogenic and occurs after pelvic surgery. Early diagnosis and treatment of urinary endometriosis are important to prevent renal failure [4].

Content is available online at https://erwejournal.com/
Early diagnosis of bladder endometriosis using various diagnostic methods. Cystoscopy can only see endometriotic lesions in the bladder mucosa but cannot determine the extent of endometriotic lesions. Treatment varies in each case according to the severity and location of the involvement [5].

Laparoscopy and cystoscopy combined surgery is an option for partial cystectomy for muscle-invasive bladder endometriosis not included in the bladder mucosa, in cases where the lesion is in the submucosal transmural space. In the present case, a CT scan showed ill-defined mildly enhancing soft tissue density within the vesicouterine region showing loss of fat planes with the posterior wall of the urinary bladder. The patient was planned for cystoscopy and endometrioma was resected using a resectoscope. After 2 months of treatment no focus on endometriosis in the bladder. Symptoms of dysuria, and menstrual haematuria decreased.

Following endometrial resection, the patient was given inj. leuprolide depot and tablet dienogest. Leuprolide is a modified version of a gonadotropin-releasing hormone, the drug inhibits the production of estrogen, and without estrogen, endometrial glands become inactive. This decreases the growth of uterine tissue outside the uterus.

Dienogest is a new generation progestin, that reduces endometriotic lesions through a number of biological mechanisms. Dienogest is associated with relatively moderate inhibition of gonadotropin secretion, leading to a reduction in the endogenous production of oestradiol. When given continuously, dienogest induces a hypoestrogenic, hypergestagenic local endocrine environment, causing a decidualization of endometrial tissue followed by atrophy of the endometriotic lesions.

**Conclusion**

Bladder endometriosis should be considered for cystoscopic/laparoscopic treatment in women of childbearing age with urinary symptoms unresponsive to conventional therapy. Effective treatment of bladder and urethral endometriosis is best done in collaboration with a team of doctors familiar with endometriosis, such as a gynecological endoscopist, radiologist, and urologist.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his/her consent for his/her images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published, and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

**Conflict of Interest:** Nil

**Financial Disclosure:** None
References


2. Tsamantioti ES, Mahdy H. Endometriosis. [Updated 2023 Jan 23]. In: StatPearls [Internet].

