Abdominal Endometriosis Arising in an Exstrophy Patient

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INTRODUCTION

Bladder exstrophy is a rare congenital anomaly. Associations with complete duplication of the genitourinary and gynecological systems have been reported. We describe a case of an abdominal swelling in an exstrophy patient which revealed endometriosis.

CASE REPORT

A 29 years old nulliparous female presented to the urology outpatients with a four months history of an intermittently enlarging abdominal swelling located over a scar. Her past history was remarkable for bladder exstrophy for which she underwent primary bladder closure on the third day of life. This had been followed by a succession of urological procedures over seven years. She had initiated self-intermittent catheterization following this. Her menarche had been at the age of thirteen. On presentation she described episodic swelling over her inferior abdominal wall beneath her laparotomy scar. It was unrelated to her menses and no systemic upset occurred.

On examination a firm indurated area was noted beneath the skin within the rectus sheath. Subsequent magnetic resonance imaging (MRI) confirmed the presence of a 3.5 cm × 2.7 cm × 3.9 cm enhancing mass within her abdominal wall which was separate from the peritoneum (Figure 1).

Under general anesthesia an excisional biopsy was performed. Intraoperatively a mass was found within the reconstructed rectus sheath. The peritoneum was opened and a segment from the dome of the bladder was removed as the mass was attached to it inferiorly. The remainder of the bladder was unremarkable.
skin covered double bladder exstrophy has been reported along with complete duplication of the mullerian structures and also separately with colonic sequestration with a normal hindgut. Following progression into adulthood the reconstructed female exstrophy patient may face problems with parturition, sexual health and gynecological concerns. Krisoloff and colleagues have found that multiple surgical procedures with scarring in the abdominopelvic area may have a detrimental effect on body image and sexual function. Successful pregnancies have been reported in patients who have undergone exstrophy repair but caesarean delivery is recommended. Gynecological complications of exstrophy repair include mucocolpos and vaginal stone formation. Burbige and colleagues studied female exstrophy patients and found that none had endometriosis. Our patient was nulliparous and denied dyspareunia or endometriosis. We describe an abdominal mass in a corrected female exstrophy patient, which when excised, revealed endometriosis. Reports exist of dual pathologies in exstrophy patients who underwent reconstruction in adulthood. Kitajima and colleagues reported a case of scar endometriosis in a 26 years old exstrophy patient who underwent repair as an infant. Our case differs, however, as the ectopic deposit was painless and unrelated to her menstrual cycle.

CONCLUSION
We believe this to be the second reported case of scar related abdominal endometriosis in an exstrophy patient. As the long term follow up of this population is predominantly urological, female exstrophy patients with gynecological problems may present to the urologist. Therefore, the differential diagnosis of an abdominal mass in a female exstrophy patient should include gynecological pathologies such as ectopic endometrial tissue.

CONFLICT OF INTEREST
None declared.

REFERENCES
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