

An Atypical Presentation of Bladder Carcinoma in a Postmenopausal Woman

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ABSTRACT

Transitional cell carcinoma (TCC) or urothelial carcinoma is the most common type of urinary bladder cancer. It roughly accounts for 95% of bladder cancer. It can occur due to cigarette smoking, aniline dye used in paint industry, and agrochemicals. TCC can be papillary, sessile, or carcinoma *in situ*. These patients most commonly present with hematuria and dysuria. Also, increase in frequency and urgency are also noted. Here, we present a case of high-grade transitional cell carcinoma of bladder which, presented as a pelvic mass with no history of hematuria or dysuria. All the tumor markers were normal and imaging was suspicious, so diagnostic laparoscopy was planned, which ultimately converted to laparotomy due to intraop bleeding. It was subsequently shown to be originated from bladder. This case also indicates the role of good imaging analysis in a pelvic mass despite normal tumor marker, and it subsequently helps in the planning of the management.

Keywords: Bladder carcinoma, Imaging in pelvic mass, Pelvic mass, Transitional cell carcinoma.

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INTRODUCTION

Transitional cell carcinoma (TCC) or urothelial carcinoma is the most common type of urinary bladder cancer. It roughly accounts for 95% of bladder cancer.¹ It arises from transitional epithelium that lines inner surface of the bladder. It can occur due to cigarette smoking, aniline dye used in paint industry, and agrochemicals. TCC can be papillary, sessile, or carcinoma *in situ*.² Most common site of metastasis outside pelvis is bone of which most common site is spine. Histopathologically, they are graded as per WHO 2004 classification into three groups—low malignant potential, low grade, and high grade.

These patients most commonly presents with hematuria and dysuria.³ Also increase in frequency and urgency are also noted.

CASE DESCRIPTION

Our patient a 62-year-old female P2L2 (both VD, LCB—15 years back and BTL done) came with the complain of abdominal distension for past 15 days. It was associated with anorexia but no complain of any bladder or bowel symptoms. She had a history of TAH + RT salpingo-oophorectomy in 2010 due to right tuboovarian mass. Detailed operative notes and histopathology of previous reports were not available.

On clinical examination, she had a 16-week-sized midline mobile solid cystic mass felt per abdomen which was nontender. On speculum examination, her vault was healthy and a large 8 × 8 cm-sized solid cystic mass felt with good mobility and nontender on bimanual examination. Her tumor markers report suggest CA 125—15.39 and CEA—2.27. USG suggested 10 × 9 × 12 cm-sized multilobulated solid cystic pelvic mass.

CECT as in [Figure 1](#) showed irregular lobulated heterogeneously enhancing lesion in pelvis centered in right adnexa and extending to left adnexa and lower abdomen with multiple calcific foci (? left ovarian mass) with multiple left paraaortic nodes with possible thickening of rectosigmoid and possible hepatic metastasis.

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The patient was subsequently planned for diagnostic laparoscopy and proceeded. On laparoscopic examination a large 6 × 7 cm-sized proliferative sessile pelvic mass was seen adhered to bladder and small gut. Left ovary appeared healthy. During the procedure of taking biopsy from the mass, the tumor bled profusely leading to conversion to laparotomy.

On exploration, there was flimsy small gut adhesion, mass was attached to bladder, and left ovary was separated and healthy. Other intra-abdominal organs were normal. The mass is completely excised along with part of urinary bladder to get free margin. The bladder wall was repaired in Vicryl 2-0 with two layers. Patient was subsequently discharged with catheter *in situ* on day 6. Her HPE report subsequently came out to be high-grade transitional cell carcinoma, and her catheter was removed after 6 weeks and she was sent to medical oncology department for chemotherapy. [Figure 2](#) shows the mass.

DISCUSSION

Bladder carcinoma usually presents with hematuria or dysuria, but in some cases, it can present with features mimicking a pelvic mass.⁴ Clinical examination may suggest an ovarian mass.

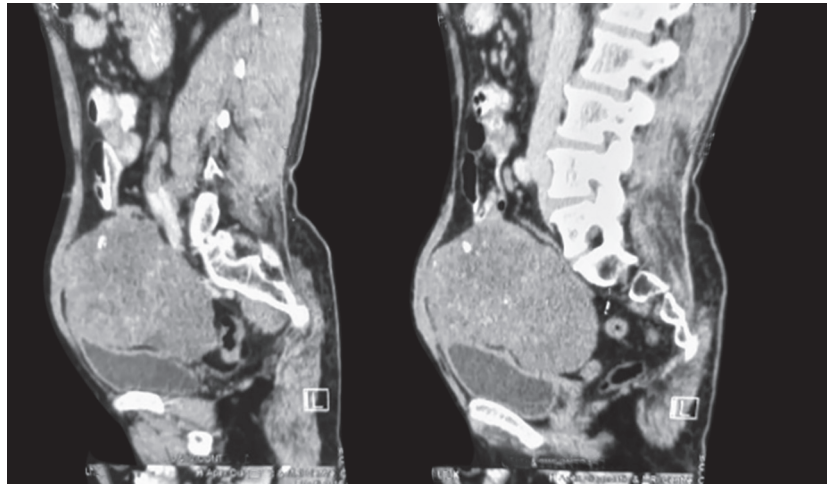


Fig. 1: CECT picture of the mass

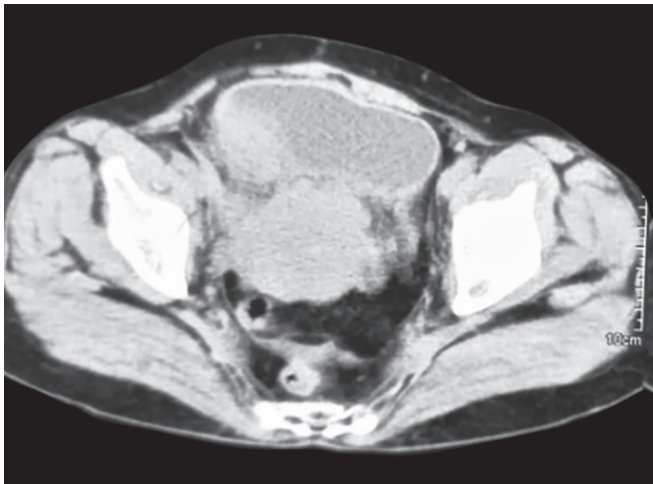


Fig. 2: CECT picture of the mass in axial section



Fig. 3: Bladder mass picture with part of bladder tissue

But careful analysis of imaging and tumor marker may suggest otherwise. In our case, despite being a solid cystic mass, absence of ascites and normal tumor marker suggested careful imaging review. CECT review indicated fat plane is not maintained between bladder and mass (due to probable primary origin or metastasis in the bladder). Therefore, we planned for a diagnostic laparoscopy. Laparoscopy distinctly showed a normal ovary separated from bladder mass. But the biopsy from the bed of this mass-produced profuse hemorrhage, leading to exploratory laparotomy. The mass is subsequently removed, and HPE showed it to be a high-grade TCC. A similar case was reported in a 18-year-old patient presented with pelvic mass with microscopic hematuria and subsequently diagnosed to be a bladder cancer (Figs 3 and 4).

CONCLUSION

Urothelial cancer or TCC can sometimes present as a pelvic mass with no bladder symptoms. Careful clinical examination is required to induce suspicion in the clinicians' mind.⁵ However, tumor marker analysis and CECT analysis are of paramount importance in all cases of pelvic mass so that preoperative planning for each case can be

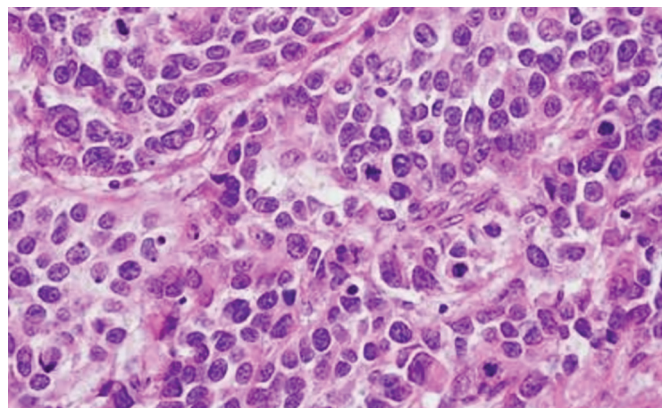


Fig. 4: HPE picture of high-grade TCC

done properly. Good CECT analysis may detect or create suspicion in this type of cases. Also, during the procedure of biopsy, it should be taken from the edge of the mass rather than the tumor bed as it tends to bleed much.

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