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Cystitis Glandularis: A Case Report of a Rare Benign Bladder Tumor

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1. Introduction

Pseudotumor or florid cystitis glandularis is the bladder urothelial of the which mainly affects humans [1,2,3].

It is facilitated by chronic and recurrent irritation of the bladder. Because of its non-specific symptoms, it poses a diagnostic problem with malignant bladder tumors [4]. We report 1 case of cystitis glandularis. In the light of this case, we will discuss the diagnostic and therapeutic aspects as well as the prognosis of this condition.

2. Patient's History

He is a 32-year-old male patient with no known medical history, the main signs of the disease were pollakiuria and episodes of uncomplicated renal colic resistance to analgesics; Urinalysis of the urine did not isolate any germ, there was no microscopic hematuria. The result of an ultrasound (Figure 1) of the bladder revealed a thickened budding wall of the bladder prominently on the left, a supplemented uroscan was carried out (Figure 2) which also revealed a bladder tumor lesion process of the left postero-lateral of the bladder, of which part extends to the meatus ipsilateral ureter with moderate upstream hydronephrosis. Cystoscopy showed a thickening at the trigone and the left peri-meatic level. Complete endoscopic resection was performed, and a pathological study was conducted which returned in favor of glandular metaplasia with no sign of malignancy (Figures 3 and 4).

Figure 1: The result of an ultrasound of the bladder revealed a thickened budding wall of the bladder prominently on the left

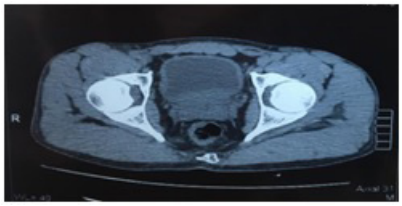


Figure 2: A supplemented uroscan was carried out (figure 2) which also revealed a bladder tumor lesion process of the left postero-lateral of the bladder

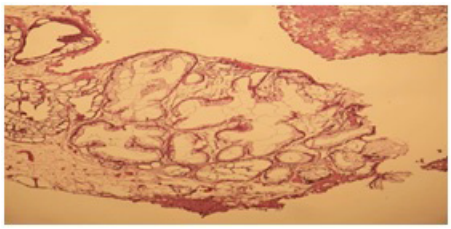


Figure 3: HEx40 glandular structure Mucus secreting dissociating the bladder's Chorion

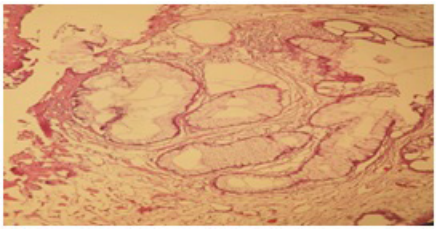
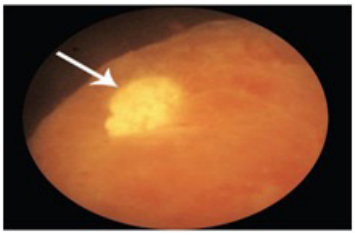


Figure 4: HEx200 glandular structure mucus-secreting with small nuclei in the basal position



Picture 5: Cystoscopic image of glandular cystitis showing a "cobblestone" appearance with a focal mass of polyploidy shape (arrow) (21).

3. Discussion

The incidence of cystitis glandularis is estimated to be around 1% [5,6]. It mainly affects humans, a case of a 25-year-old woman with Cystitis glandularis was reported by DAVID [7]. The most affected age group is around 50 [3,8], with cases reported in children as well [9,10]. The etiopathogenesis of this condition is poorly understood. It is almost always in association with situations that lead to chronic inflammation of the bladder. The latter has led to the view that obstruction of the posterior urethra, urolithiasis, and chronic and recurrent urinary tract infections are the main etiologies of cystitis glandularis [7,11]. The germs involved are, in decreasing order of Escherichia coli, Proteus, Pseudomonas, and finally Chlamydia [9]. In our study, the urinalysis performed came back sterile. Cystitis glandularis is associated in 75-80% of pelvic lipomatosis cases [11,12]. This association seems to be explained by stasis and chronic irritation caused by peri bladder lipomatous infiltration. There are two histological types of cystitis glandularis [13,14]. The so-called typical histological form, the most frequent, is a simple mucinous flexion of the bladder epithelium. This form has no specific clinical translation. The one with the histological form of the intestinal or colonic metaplasia is rarer than the previous form. It is characterized by the presence of inflammatory chorion, of colonic-type glands on the superficial surface. These glands are made up of unilateral tubular structures, cluster in pseudo-lobules, or proliferate in large clusters in a pseudo-tumor form (Florid form) [2,6]. Sometimes the glands have a colonic mucus-like organization with the mucus having the same histochemical characteristics as intestinal mucus [2,13]. It sits with predilection at the level of the neck and the trigon region of the bladder [9]. In the pseudo-tumor form, the symptoms are linked to how large the bladder is affected. There are several modes of revelation [3,6,12]:

Chronic irritative symptoms of the bladder; our patient complained of pollakiuria and lower back pain.

- Obstructive signs such as dysuria, urinary retention, or even renal pain leading to suspicion of dilation of the upper apparatus linked to the invasion of the two orifices by the Florid form (pseudotumor form) and or the enclosing of the pelvic ureters by pelvic lipomatosis associated [8,12].

- More rarely, the elimination of mucus or tissue debris in the urine and obstructive renal failure can also be associated with pelvic lipomatosis [11,12,15].

The physical examination of the patient is often non-concluding. The radiological signs of pseudo cystitis glandular are nonspecific and may sometimes point to bladder carcinoma. Ultrasound and especially abdominopelvic CT scan with intravenous urography image usually show one or more masses most often located on the trigone and which may sometimes extend to the entire bladder [3,6,16,17]. On cystoscopy, the lesions appear as cysts 1 to 15 mm in diameter giving a pseudo-tumor oedematous appearance deforming the trigone and adjacent parts of the lateral surfaces [2,6]. Diagnostic certainty is based on pathological examination which reveals cylindrical glandular tissue at the level of the mucosa and the submucosa [3,15]. However, it is sometimes difficult to differentiate this lesion from an adenocarcinoma or an invasive urothelial carcinoma of the nest's type ("nested variant carcinoma"), mainly in the form of the intestinal type [3,18]. The basic treatment for this condition is eradication of all sources of chronic bladder irritation [2,6,7,9]. Endo vesical installations have been used to improve the symptomatology of patients: anti-angiogenic installations, hydrocortisone, and dimethyl sulfoxide, and low molecular weight heparins [19]. Even radiotherapy and chemotherapy have been used [12]. But none has proven its effectiveness. In major pseudo-tumor forms, resorting to endoscopic tumor resection is generally sufficient for most authors [2,7,9,15]. More rarely, YAG laser photocoagulation has been used [20,21]. For the extensive forms with a reduced capacity bladder and dilation of the upper urinary tract and the recurrent forms, some perform bilateral ureterovesical reimplantation at the level of the bladder dome, an augmentation enterocystoplasty, or finally a cystectomy (partial cystectomy, cystoprostatectomy with or without continental urinary diversion) [3,8,15]. Preserving the prostatic shell during cystoprostatectomy has allowed patients to maintain sexuality and avoid urinary incontinence [3,8].

No effective treatment has been described for pelvic lipomatosis. Surgical fat resection is generally not recommended because of the difficulty of dissection and the risk of vascular and nerve damage to the pelvic organs [11]. The evolution of cystitis glandular is controversial. In its florid form, it is considered a precancerous lesion due to its possible association with adenocarcinoma [11,16]. Its transformation into adenocarcinoma remains rare and it also depends on its persistent exposure to unfavorable factors [3,16]. In our screening, no patient presented a malignant degeneration

which was probably due to the short duration of follow-ups (mean follow-up of 40 months). Some people consider glandular cystitis to be a benign lesion. They believe it goes away once the irritant factor stops.

Patients with pelvic lipomatosis have a higher incidence of venous thrombosis and obstructive renal failure (40% after No progress) [11,12]. The minor form does not seem to have any particular prognostic value, Contrary to the latter the pseudotumor form requires radiological (CT), biological (renal function, urinary cytology), and cystoscopic monitoring.

4. Conclusion

Tumor-like cystitis glandular is a rare benign condition whose, radiological and endoscopic signs are suggestive of a malignant bladder tumor. The diagnostic certainty is always histological. Finding and treating an irritant cause is essential. Endoscopic resection is generally sufficient to control it, but heavy resection is required in certain aggressive and disabling forms. In view of the risk of malignant degeneration, long-term monitoring is essential.

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