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Small bowel adenocarcinoma presenting with recurrent urinary tract infection

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DESCRIPTION

A 75-year-old Caucasian lady presented with a 3 month history of recurrent urinary tract infections (UTIs) and haematuria. She denied pneumaturia. Her medical history was unremarkable.

Cystoscopy revealed a large lesion on the right bladder. Excision biopsies confirmed a villous adenoma with low-grade dysplasia. The initial diagnosis was of an adenoma arising from a urachal remnant. However, an abdomino-pelvic CT scan showed a terminal ileal mass including the appendix adherent and in continuity with the bladder mass (figures 1–3). On the basis of this report, colonoscopy was considered but after multi-disciplinary team discussion we proceeded directly to open surgery by performing a radical right hemicolectomy with en-bloc partial cystectomy.

Histology reported a well-differentiated mucinous adenocarcinoma arising from a villous adenoma in the terminal ileum. Transmural malignant fistulation into the bladder was present. All resection margins were clear with final staging pT4_bN0V1R0Mx. In total, 95 mm of ileum was resected (figure 4).

Postoperative recovery was uncomplicated with a cystogram on day 10 showing no evidence of leak.

Entero or appedico vesical malignant fistulas are rare but they are a recognised cause of recurrent UTIs. Enterovesical fistulae are commonly benign, caused by inflammatory bowel disease, infection or radiation enteritis. This case initially presented with urological pathology and biopsy showed a villous adenoma. It is possible that this may have arisen in a urachal remnant or even a primary bladder tumour but the CT scan identified primary bowel pathology. Primary bladder adenocarcinoma accounts for less than 0.5% of bladder tumours with the majority arising from a urachal remnant.

Learning points

- ▶ Malignant enterovesical fistula is a rare but important cause of recurrent urinary tract infection.
- ▶ A primary villous adenoma on a bladder biopsy should raise suspicions of a urachal remnant.
- ▶ This case demonstrates an alternative.

Competing interests None.

Patient consent Obtained.

Figure 1 Axial CT showing bladder lesion.

Figure 2 Coronal CT showing bladder mass with involvement of the distal small bowel and appendix.

Figure 3 Sagittal CT showing the bladder mass, with involvement of small bowel loop.

Figure 4 Image of open specimen depicting the appendix (green arrow) extending into the mass including the bladder cuff (blue arrow) and ileum. The site of fistulation is shown (red arrow). The mucinous nature of the tumour is apparent. The appendix appears to be involved but was normal histologically.

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