Spontaneous abortion through the bladder

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Amenorrhea, menouria (cyclical hematuria) and absence of urinary incontinence that characterize the Youssef’s syndrome [1] is the common presentation of vesicouterine fistula. Women with vesicouterine fistulas are generally considered to be sterile [2].

Para 1 who presented with massive hematuria to emergency ward, posed a diagnostic dilemma. She had undergone emergency cesarean section for malpresentation 18 months ago; indwelling urinary catheter was kept for 8 postoperative days and had not resumed her menstruation after the cesarean. She denied any attempt at uterine curettage. There was no history of urinary incontinence. On examination, there was minimal vaginal bleeding. Cervical os was open and bits of fleshy tissue were obtained through the os during examination. Trans-abdominal ultrasound showed an 8–10-cm echogenic mass in the bladder (Fig. 1) and an irregular echogenic mass filling the lower uterine cavity with communication between the bladder and lower part of uterus. Cystoscopic examination detected 500-ml clots along with fleshy material inside the bladder and a 2×2.5-cm defect in supratrigonal region of the bladder. Serum beta hCG was 68.7 mU/ml. Histopathological examination of material collected from vagina and bladder revealed products of conception. Following cystoscopic lavage, she remained amenorrheic, but had infrequent hematuria. The hysterogram done 9 months later showed the persistence of communication between the uterus and bladder (Fig. 2). The reparative surgery is planned.

In the present case, the patient had amenorrhea and remained continent. The first presentation was with massive hematuria. The working clinical diagnoses considered were perforation into the bladder at termination of early pregnancy, cervical cancer infiltrating the bladder and some disease of urinary tract, in that order. History and the investigations carried out suggested otherwise. The patient probably had had injury to the bladder during cesarean delivery as evidenced indirectly by history of indwelling bladder catheter for a longer duration. The patient did not manifest with menouria since she remained amenorrheic due probably to lactation. The patient is likely to have conceived at the very first ovulation, which is not uncommon. The spontaneous
abortion occurred through the fistulous tract into the bladder.

Unlike the usual presentations of patients with vesicouterine fistula, the case reported had no menouria at the outset. She was not incontinent. She presented with spontaneous abortion of intrauterine pregnancy through the bladder. It has been shown in rabbits that surgical creation of a vesicouterine fistula into one horn of the uterus did not preclude with normal capacity for implantation in the contralateral horn [3].

It is emphasized that, whenever a sexually active woman with previous cesarean delivery presents with hematuria, possibility of vesicouterine fistula should be kept in mind.

References

