

Painless gross haematuria

無痛而肉眼可見的血尿

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Inflammatory pseudotumour is a benign mesenchymal lesion that has distinct pathological features. Patients often present with haematuria, abdominal pain or recurrent cystitis. There are overlapping features with bladder sarcoma in presentation, age range, and size, but the pseudotumour does not metastasise. Awareness of this unusual lesion is important to prevent its misinterpretation. Complete surgical excision of the tumour mass is the treatment of choice. (*Hong Kong j.emerg.med.* 2007;14:58-59)

炎性假瘤是一種良性間充質病變，它有清晰的病理特徵，病者通常呈現血尿、腹痛或復發性膀胱炎。它與膀胱肉瘤在徵狀、年齡範圍及大小方面有部份相同，但炎性假瘤並不會擴散轉移。認識這罕見的病變以防誤診是重要的。治療應選擇以外科手術完全切除腫瘤。

Keywords: Bladder neoplasms, granuloma, haematuria, ultrasonography

關鍵詞：膀胱腫瘤、肉芽瘤、血尿、超聲波造影術

Case summary

A 44-year-old Chinese male presented with a complaint of painless whole stream gross haematuria for several weeks in 2003. There was no previous history of cystitis, trauma or surgery of the urinary system.

Ultrasound examination revealed a 4 cm lobulated medium echogenic intra-luminal nodular mass arising from the right lateral wall of the bladder. The mass demonstrated mural infiltration but did not extend into the adventitia. Within the mass, both arterial and venous vascular flows were demonstrated (Figures 1, 2 & 3).

Cysto-urethroscopy demonstrated a 4 cm sessile, polypoid shaped nodular mass that had a wide base. The tumour mass was resected. The patient recovered well after treatment.



Figure 1. Transabdominal ultrasound of the bladder demonstrating a 4 cm lobulated medium echogenic intra-luminal nodular mass arising from the right lateral wall of the bladder.

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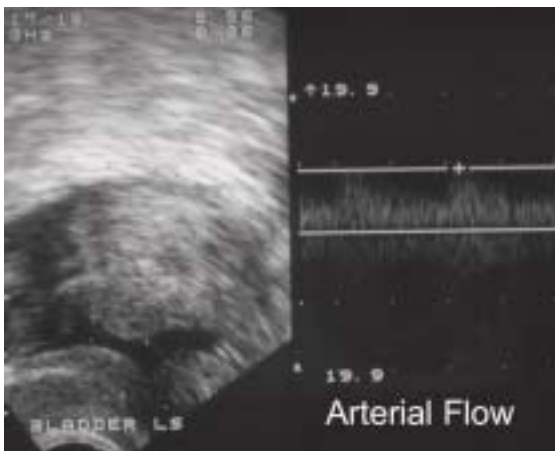


Figure 2. Transrectal Doppler ultrasound showing arterial flow pattern within the tumour.



Figure 3. Transrectal Doppler ultrasound showing venous flow pattern within the tumour.

Discussion

Since inflammatory pseudotumour of the bladder was first described in 1980, there have been a few reported cases in the English literature. This bladder tumour is usually found in adults and rarely in children. Patients often present with haematuria, abdominal pain or recurrent cystitis. The tumour has been described to reach 13 cm in size.¹⁻³

The tumour mass on contrast-enhanced computed tomography has been described as a lobular mass with a broad band of ring-like peripheral enhancement arising from the bladder. There are associated bladder wall thickening and non-specific soft tissue changes in the perivesical fat. Magnetic resonance imaging reveals the tumour better, as a poorly defined mass invading deeply

into the muscle of the bladder. The mass appears as isointense to skeletal muscle (T1-weighted image); peripheral isointensity with central hyperintensity (T2-weighted image); and broadband of ring-like peripheral enhancement after gadolinium contrast. The imaging findings correlate with the histological findings of central necrosis with peripheral compact fascicles of spindle-shaped cells.²

This unusual non-neoplastic lesion may be mistaken for a bladder leiomyoma or sarcoma/carcinoma. In the case of leiomyoma, the tumour is often well circumscribed while sarcoma/carcinoma may show invasion into the surrounding structure. Histological confirmation is essential. The criteria that best differentiate sarcoma from inflammatory pseudotumour are the presence of necrosis at the tumour-detrusor muscle interface in muscle-invasive cases, and nuclear atypia.¹

Although inflammatory pseudotumour overlaps with sarcoma in presentation, age range, and size, it does not metastasise and remains histologically distinct from low-grade sarcoma. Awareness of this unusual lesion is important to prevent its misinterpretation.

Inflammatory pseudotumour is a benign, inflammatory or reparative, mesenchymal lesion that has distinct pathological features. The treatment of choice is complete surgical excision and in most cases, clinical follow-up demonstrates no evidence of recurrence up to a period of two years.⁴

References

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