SAS Journal of Surgery
Abbreviated Key Title: SAS J Surg
ISSN 2454-5104
Journal homepage: https://www.saspublishers.com

OPEN ACCESS

Urology

Bladder Lymphoma in a Young Patient

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DOI: 10.36347/sasjs.2023.v09i11.003 | **Received:** 28.09.2023 | **Accepted:** 30.10.2023 | **Published:** 05.11.2023

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Abstract **Case Report**

Bladder lymphoma is rare. We report here a case of a 39 year old man, who had consulted the emergency room for anuria for 2 days, the blood test showed a creatinine level of 1093mcmol/l with a creatinine clearance of 5ml/min, the imaging revealed a parietal, bladder and both terminal ureters thickening with dilatation of the upper excretory tract. The patient underwent a left-sided urinary diversion with bladder resection and subsequent chemotherapy. After 5 months the patient was considered to be in remission and was weaned from the double-damage catheter.

Keywords : Lymphoma of the bladder, cystoscopy, endoscopic resection, jj probe, chemotherapy.

INTRODUCTION

Primary bladder lymphomas are exceptional due to the low lymphoid tissue content of the bladder [1]. Haematuria is the revealing sign in 80% of cases, other irritative signs may be present, pain and alteration of the general state are rare [2]. Bladder ultrasound and cystoscopy are the first-line examinations, but there are no structural features that point to lymphoma [3], and diagnostic certainty is provided by histological examination of the resection chips [4]. Lymphomas are chemosensitive and therefore chemotherapy remains the first-line treatment considered [5].

OBSERVATION

We report here a case of a 39 year old man, who had consulted the emergency department for anuria for 2 days, without haematuria or other associated clinical signs. His history included an attack of renal colic. The clinical examination was unremarkable.

The biological work-up carried out in the emergency room was very disturbed with hyperkalaemia at 5.6 mEq/L, creatinine at 1093mcmol/L with a creatinine clearance of 5ml/min. On emergency CT scan: there was parietal, bladder and both terminal ureters thickening. There was no lithiasis but both kidneys were dilated.

The patient was admitted urgently to the operating theatre for urinary diversion, on cystoscopy the trigonal region was found elevated and invaded by a huge tumour lesion with bleeding at the slightest contact with the bladder mucosa. The two ureteral meatus were not visible (figure 1).

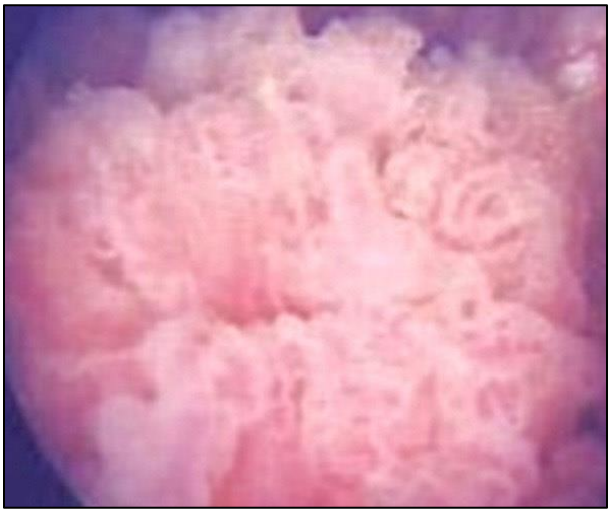

Figure 1: Cystoscopic appearance of bladder lymphoma in our patient

An endoscopic resection of the trigonal region was performed to clear the ureteral meatus.

After extensive resection, the left ureteral meatus, the side where the kidney was most functional, was cleared. The teflon-coated guide was able to overcome the obstacles and then a progressive dilatation

of the ureter in order to be able to install an external ureteral catheter 7 which brought back clear urine. It was not possible to drain the right kidney and as the patient was under spinal anaesthesia, we could not perform a percutaneous nephrostomy on the right side, but this was planned for the next few days.

Biological check-up the next day: creatinine level at 978 mcmol/l, normalization of kalemia.

Biological check-up at D+3: creatinine level at 507 mcmol/l, the rest of the work-up without any particularity.

Biology control on day 7: creatinine level at 89mcmol/l, creatinine clearance at 95ml/min. Anatomopathology was in favour of a diffuse large B-cell lymphoma with a germinal centre B-cell like immunohistochemical profile.

After one week, the external ureteral catheter was replaced by a JJ, after discussion with our haematology colleagues, it was decided not to consider external drainage of the right kidney to avoid infectious problems during chemotherapy.

The patient had started chemotherapy. PET scan at 1 month: hypermetabolic thickening of the posterior bladder wall associated with a probable hypermetabolic and obstructive lesion of the ureter.

After 5 months, the patient was doing well, he had a follow-up CT scan which showed a small right kidney, a normal left kidney and the absence of dilatation of the excretory cavities on the right and left, the secretion was early and symmetrical on both sides. The PET scan confirmed the absence of a hypermetabolic lesion.

The patient was considered to be in remission with a PET scan confirming the absence of hypermetabolic lesion, was weaned from his double-dose catheter, and haematologically there was no long-term treatment apart from VALACICLOVIR 500 mg/day for 6 months.

DISCUSSION

Classically, primary bladder lymphomas occur mainly in women after the age of 40. Men are 6 times less affected [6]. Haematuria is the revealing sign in 80% of cases [7]. Pain and changes in general condition are rare. Renal failure, as in our case, is an exceptional finding. On cystoscopy, the appearance is that of a solid, rounded mass, single or multiple, raising the mucosa, which is often ulcerated and haemorrhagic. The intravesical location is often retro-trigonal or lateral [8]. The diagnosis of bladder lymphoma is confirmed by histological study. Chemotherapy is often used as a first line treatment as most lymphomas are chemosensitive.

CONCLUSION

Primary bladder lymphoma is a rare form of bladder tumour. The most common clinical sign is haematuria. Confirmation of the diagnosis relies on histological study as the clinical, endoscopic and radiological signs are not specific. The prognosis is often favourable for the primary tumour, as lymphoma is sensitive to chemotherapy.

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