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Uraque Cyst Revealed Late by Infection About one Case and Review of the Literature

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Abstract **Case Report**

Uraque cysts are rare and discovered in adulthood. Ultrasound and computed tomography allow the diagnosis. Treatment is rarely conservative because of the risk of recurrence or malignant degeneration. We report a rare case of uracha cysts revealed by superinfection**.**

Keywords: urachal, urachal cyst, complication.

INTRODUCTION

The urachal is a tubular embryonic remnant of allantoic origin interposed between the peritoneum and the transversalis fascia [1, 2]. It is limited laterally by the umbilical artery fiber cords which usually involve at birth but can persist and will be the cause of several types of malformations. We report in this work, a case of superinfection urachal cysts.

OBSERVATION

This is a 55-year-old patient, with no particular pathological history, who has had a painful hypogastric swelling for 1 month (figure 1) evolving in a febrile context and deterioration of the general condition, without other associated signs, motivating the patient to consult the emergency room. On clinical examination, the patient was conscious, stable, feverish at 39°c, slightly discolored conjunctiva. Palpation allowed to find a painful soft hypogastric mass with the presence of inflammatory signs. Pelvic touch was normal. The biological assessment showed anemia at 7g / dl, at leukocytosis at 17000 / mm, CRP at 144 mg / L. An abdominal TDM (figure 2) showed a parietal collection under the umbilical Continuing with the bladder dome, hypodense with hydroaeric level, measuring 11*5*10 cm, associated with a diffuse and regular thickening of the above bladder-like grelic loops which come into contact with the associated collection, a subcutaneous emphysema. The patient was put on antibiotic treatment with a surgical exploration which allowed the evacuation of a purulent collection (300cc), to note that the aponeurosis of the right was dilapidated, torn and that the bladder wall was intact, an excision of the cyst was carried out. The histological study was in favor of a uraquian residue with acute inflammation. The evolution was marked by clinical and biological improvement and the patient was declared out on the fifth day.

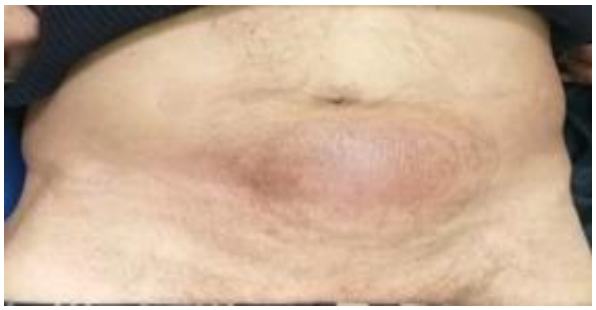

Fig-1: inflammatory tumefaction of the periumbilical region

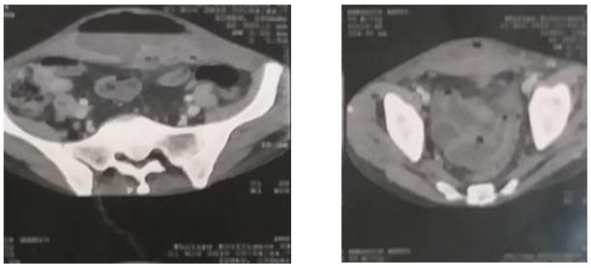

Fig-2: Abdominopelvic CT scan showing a superinfected urachal cyst (a), urachal cyst not communicating with the bladder (b)

DISCUSSION

The urachal is a fibrous cord that attaches the bladder dome to the umbilicus, and during embryonic life, it allows communication between the bladder and the allantoic [1]. Clinical expression the persistence of this allantoic duct at birth may be variable revealed by complications [2]. The accumulation of mucinous and serous secretions in the canal of the urachal, which occurs most often in the lower 1/3 of the canal, will be responsible for cysts of the ouraque and which can be complicated by secondary infection or a real abscess in adults [1]. The diagnosis of a urachal cyst is often difficult, and one must think about it in front of a suprapubic parietal mass simulating a hernial strangulation or abdominal pain may be the only symptom of disease [3]. These cysts are most often not very symptomatic but can be complicated in the form of hemorrhages or intra cystic infections, fistulas in the skin or bladder responsible for recurrent urinary tract infections, in an exceptional way of peritonitis secondary to an intra peritoneal rupture or malignant degeneration [3,4, 5]. In our case, the diagnosis of the cyst was revealed late at the stage of infectious complication. Performing a cystography or a fistulography, or a uroscanner with a late stage is essential [6]. On ultrasound, the urachal cyst appears in the form of an echogenic, heterogeneous mass with sometimes a perilesional vascular corbelling which can wrongly suggest a primary tumor of the urachal. On computed tomography, it appears as a mass extending from the umbilicus to the bladder dome. The treatment of cysts of the urachal is based on surgery and consists of an update flat and to a drainage of the collection then in a second time to excise the remainde [7]. The simple drainage is insufficient, an excision of the whole cyst must be carried out to avoid recurrences or the possibility of carcinomatous degeneration.

CONCLUSION

The diagnosis of urachal cyst requires complete excision of the urachal duct, removing the cyst, given the risk of complications, recurrence and distant degeneration. They must be diagnosed earlier to avoid complicated forms.

Conflict of Interest: The authors declare that they have no Conflict of interest.

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