Case Report

# Fetus in bladder

**Kailash Banale, Tarun Javali, Prakash Babu, G. S. Jyothi[1], Prathvi Shetty, H. K. Nagaraj, Gaurishankar S.**

Departments of Urology, and [1]Gynecology, M.S. Ramaiah Hospital, Bangalore, India

## ABSTRACT

This is the first reported case of vesicouterine fistula presenting with a fully formed dead fetus in the urinary bladder.

**Key words**: Fetus in bladder, hematuria, termination of pregnancy, vesicouterine fistula

## INTRODUCTION

Vesicouterine fistula is the least common of all the urogenital fistulae, representing 1-4% of all cases.[1] The vast majority of vesicouterine fistulae are secondary to iatrogenic causes, the most common being lower segment cesarean section.[2] The less frequent causes include induced abortion, dilatation and curettage, vaginal birth after previous cesarean section, obstructed labor, forceps delivery, placenta percreta, migrated Intra Uterine Contraceptive Device and brachytherapy.[2] The main symptoms of VUF (vesico-uterine fistula) are urinary incontinence, cyclic hematuria (menouria), amenorrhea and urinary tract infection. Most of the cases present in a delayed fashion, from weeks to years after the inciting event.[3] In such cases, the diagnosis is mainly established by clinical detection of urine or dye passing through the external cervical os or by means of a hysterosalpingogram or micturating cystourethrogram, which will demonstrate the fistulous communication.[3]

Herein, we report a unique case of vesicouterine fistula, following termination of pregnancy, in which the fetus was found lying inside the urinary bladder.

**For correspondence:** Dr. Tarun Javali,
Department of Urology,
M.S. Ramaiah Hospital, Bangalore, India.
E-mail: tarunjavali@gmail.com

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## CASE REPORT

A 29-year-old female, with 2 living children, underwent medical termination of pregnancy at 17th week of gestation in her native village. The patient did not have any medical records and did not know the method of termination adopted by the village doctor. She presented to our hospital the next day with complaints of gross hematuria and pain abdomen. On examination, her abdomen was soft and non-tender. Previous lower-segment Cesarean section (LSCS) scar was noted. Ultrasonogram abdomen showed a dead fetus of approximately 17 weeks in the bladder [Figure 1]. All other routine investigations were within normal limits. Cystoscopy showed dead fetus in the urinary bladder with a wide vesicouterine fistula 2 cm proximal to trigone in the posterior wall of bladder [Figure 2].

The abdomen was opened by a Pfannensteil incision. Cystotomy was performed and the dead fetus was removed. Both the anterior wall of the uterus and the posterior wall of the bladder were closed with absorbable sutures with omental interposition. Ligation of bilateral fallopian tubes was performed. The post-operative period was uneventful and there was no urinary incontinence after catheter removal.

## DISCUSSION

It is likely that as the patient was in her second trimester, termination of pregnancy may have been attempted by induction of labor with misoprostol, failing which the doctor must have tried dilatation and curettage. Only part of the products of conception may have been evacuated as there was no placenta when we explored the uterus. Furthermore, the right lower limb of the fetus was missing. The curette must have perforated through


**Figure 1:** Ultrasonogram showing fetus of approximately 17 weeks gestation in the urinary bladder

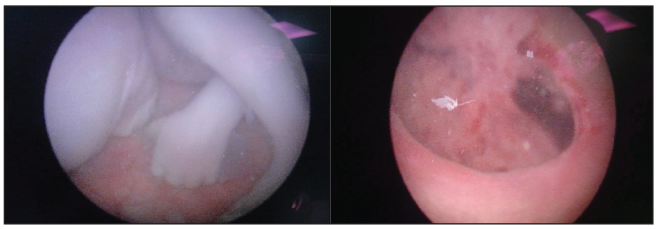

**Figure 2:** Cystoscopy images showing the dead fetus in the bladder and a wide vesicouterine fistula in the posterior wall of bladder

the anterior wall of the uterus and posterior wall of the bladder and created the vesicouterine fistula, following which the fetus may have migrated into the urinary bladder. The presence of scar tissue as a result of two previous LSCS may have been a contributory factor. The bladder is usually adherent to the scar tissue at the lower uterine segment in such cases and the posterior bladder wall may have torn along the uterine rupture line creating the fistula in this patient. The expulsive shearing force may have caused the fetus to migrate in to the urinary bladder via the fistula.

This was a unique case in the sense that the presentation was acute with the symptom of hematuria, rather than the typical symptom complex of Youssef's syndrome seen in delayed presentations.[4] Though placental invasion is known to cause vesicouterine fistula, we believe that such an event in this case is likely to have been caused by a misdirected intervention, i.e., an overzealous attempt at medical termination of pregnancy by the village doctor, and is highly unlikely to be spontaneous.

Thomas *et al*.[5] have described a patient presenting 18 months after a previous LSCS with history of hematuria with the passage of fleshy clots. Ultrasonogram showed an echogenic mass in the bladder which, on histological examination, proved to be products of conception. The patient did not have menouria as she had probably conceived during lactation amenorrhea and the fistula may have resulted during the previous LSCS. However, our case was different as a fully formed fetus was found in the urinary bladder on cystoscopic examination.

## REFERENCES

1. Iloabachie GC, Njoku O. Vesico-uterine fistula. Br J Urol 1985;57:438-9.
2. Tancer ML. Vesicouterine fistula — A review. Obstet Gynecol Surv 1986;41:743-53.
3. Park BK, Kim SH, Cho JY, Sim JS, Seong CK. Vesicouterine fistula after cesarean section: Ultrasonographic findings in two cases. J Ultrasound Med 1999;18:441-3.
4. Youssef AF. Menouria following lower segment cesarean section; a syndrome. Am J Obstet Gynecol 1957;73:759-67.
5. Guruvare S, Kushtagi P, Thomas J. Spontaneous abortion through the bladder. Int J Gynaecol Obstet 2004;87:172-3.

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