

PRESENTATION OF URACHAL CYST IN AN YOUNG ADULT WOMAN
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INTRODUCTION

Urachal cyst is a sinus remaining from allantois during embryogenesis between the umbilicus and bladder. It is where urine initially drains in the foetus during first trimester of pregnancy and usually seals off and obliterates around twelfth week of gestation and all that is left is median umbilical ligament. When there are abnormalities with sealing off of the channel during foetal development, it can cause urachal abnormalities like urachal cyst, patent urachus, urachal sinus or diverticulum. The presence of a urachal cyst is confirmed through imaging techniques. Urachal cyst treatment will depend on the status of the cyst and any existing complications. Treatment include antibiotics, drainage, and surgical removal. We should completely remove urachal remnants through surgery. Due to the potential for postsurgical infection, we prescribe oral antibiotics before removal.

CASE REPORT

A 33-year-old lady, presented with chronic pelvic pain for four months. She was initially diagnosed with Pregnancy of Unknown Location (PU) and had expectant management. During this management, she had sharp shooting pain in the pelvic region, radiating to the right side and felt ball sized hard area in the suprapubic region. Her pelvic Ultrasound showed endometrial thickness of 1.5 mm, multiple small cysts in right ovary of <5 mm size, and a cystic mass located anterior to urinary bladder wall measuring 16 x 8.4 x 15.4mm. Further assessment of perivesical mass was undertaken with MRI, showed a 23 x 14 x 17 mm lesion on the bladder, which raised suspicion of urachal cyst.

In view of her symptoms and MRI findings, patient was offered laparoscopy. While waiting for surgery, she presented with abdominal infection, which was successfully treated with course of antibiotics.

She underwent laparoscopic excision of the urachal cyst. At laparoscopy, dense omental adhesions covering lower half of abdomen and pelvis were noted. Her uterus, both fallopian tubes and ovaries were normal. Retroperitoneal urachal cyst of size 3x4 cm seen anterior to anterior wall of the bladder was excised. Bladder integrity was confirmed with Cystoscopy. Histopathological examination confirmed simple urachal cyst with predominantly transitional lining, with features of focal calcification. There was no evidence of malignancy. And she was eventually discharged from care.

DISCUSSION

The incidence of urachal cyst in adults is unknown. They largely remain asymptomatic, however approximately 35% of people present with painful symptoms that require treatment. When symptoms present, there is often co-occurring infection or other complications. Infected urachal cysts present with acute symptoms such as suprapubic pain, dysuria, fever, nausea, vomiting, haematuria, pelvic pain, and purulent umbilical discharge. The present case had only suprapubic pain at the time of admission. The other symptoms include abdominal distention or rigidity, cellulitis in the abdominal wall, palpable abdominal masses, fever, chills, painful urination or blood in the urine. Other complications include malignancy, calculi deposits. Infected cysts can leak discharge into the abdominal cavity or can rupture, which can mimic a urinary tract infection, cause painful skin discoloration or peritonitis.

During surgical removal, if doctors do not completely remove a urachal cyst, cancer may develop, which is rare type of bladder cancer (<1%). The differential diagnosis includes bladder adenocarcinoma, bladder diverticulum, vitelline cyst, Meckel diverticulum, umbilical hernia, UTI, cellulitis, PID, inflammatory bowel disease, appendicitis without rupture, bowel perforation, intra-abdominal abscess. Ultrasound is often the first test performed in suspected urachal cysts. CT may be helpful to confirm or further elucidate ambiguous findings. The treatment of non-complicated urachal cyst is total surgical excision with prophylactic antibiotics, and for urachal abscess is intravenous antibiotic therapy before surgery.

CONCLUSION

Urachal anomalies are very rare in adults and are often misdiagnosed due to the diverse clinical presentation. It is necessary to do an early diagnosis, which can help in planning appropriate surgical interventions and thereby reducing the morbidity.

