A villous adenoma of bladder/urachus origin located in the perineum

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A 60-year-old male with a background of congenital bladder extrophy presented with a painful pelvic mass after riding a push bike and sliding off the seat onto the cross bar. As a child (>50 years ago) he had undergone an abdominal perineal resection and formation of an ileal conduit, the records of which were not available.

The mass described was first noted by the patient as a non-painful lump in July 2013 and assessed with USS, which described a superficial perineal lump with complex cystic-solid characteristics communicating with a deeper tract and central pelvic cyst. No communication with other pelvic structures were identified. This was originally thought to be malpositioned seminal vesicles. MRI was recommended and this reported a 100x50x70mm multiloculated cystic lesion with components deep and superficial to the pelvic floor musculature. It was described as non-specific but had benign features without any identifiable solid component. A follow-up MRI in 2014 showed a small increase in the size of the lesion with unchanged characteristics. At this time it was felt this represented a lymphatic malformation/lymphocele. The patient remained asymptomatic and a watch and wait approach was taken. Yearly monitoring continued to show a slow increase in size only (Figure 1).

When the patient developed pain in autumn 2016 after blunt trauma, a more definitive management option was explored. Blood tests including CRP and PSA were normal. After consideration of possible options, the decision was made to surgically excise the lesion (Figure 2).

Histology of the cystic perineal lesion showed macroscopic findings of an ovoid nodule of tan fibrous tissue 80x70x45mm. Microscopic findings showed mucin-filled spaces within fibrous tissue. There was no evidence of high-grade dysplasia or other features of malignancy. The features were

Figure 1: Last pre-operative MRI scan in 2016 showing the perineal cystic lesion.
of a villous adenoma of bladder/urachal origin. Excision with clear margins was thought to be curative.

The patient was discharged the following day and made a good recovery. The agreed course of follow up was with repeat MRI. He remains pain free and has developed no long-term complications.

**Discussion**

Villous adenomas of the urinary system are rare.1,2,4,6 There are no cases available in the literature describing these lesions of bladder/urachal origin found outside the urinary system in the perineum. They have been found in the bladder, urachus, renal pelvis, ureter and urethra, and have morphologic features similar to those of the colonic adenomas.1,3,4

There are reports in the literature showing bladder/urachus villous adenomas associated with malignant tumours including adenocarcinoma, squamous cell carcinoma and urothelial carcinomas, which can metastasize or recur after initial management.2,3,5,6 It is therefore crucial to obtain tissue for histology to achieve a formal diagnosis and determine if further investigations are needed and what management is required.5,7 Good clinical outcomes have been observed in patients with isolated villous adenoma or villous adenoma plus adenocarcinoma in situ after complete surgical resection, with rarely any recurrence.5,7 Those cases with co-existing adenocarcinoma or other invasive malignancies do less well and may experience metastases or recurrence requiring further investigations and management options.3

**Learning points**

In conclusion, villous adenomas of bladder/urachal origin found in the pelvis/perineum are rare with no previous examples described in the literature. These lesions can be slow to increase in size and patients can be asymptomatic. These lesions can often be associated with malignancy so histology is of high importance. This case report highlights that complete surgical excision of these lesions with clear margins can result in good clinical outcomes.
Competing interests:
Nil.

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