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RESEARCH ARTICLE

PREGNANCY AFTER ENTEROCYSTOPLASTY: A CASE REPORT.

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Abstract

Pregnancy after enterocystoplasty remains a rare case, only few cases have been reported. It involves particular risks during pregnancy and also during delivery, hence the need for multidisciplinary obstetric and urological follow-up Here is our experience with a pregnant woman having an enterocystoplasty.

Introduction:-

Pregnancy on replacement enterocystoplasty is a very rare clinical case, we report the case of a patient who benefited from this surgery for leomyosarcoma, afterwards she was followed by us for her pregnancy. It involves particular risks during pregnancy and also during delivery. It is based on a partial cystectomy, for small superficial tumors [3] or anterior pelvectomy in case of infiltrating tumors. [4], which makes childbirth difficult especially in case of cesarienne

Case Report:-

This is a 34-years-old patient, followed for FNCLCC grade I bladder leomyosarcoma, for which she underwent an enterocystoplasty in 2014. The extension assessment did not reveal any metastasis, so she did not require chemotherapy and a regular monitoring revealed no recurrence as well as a favorable post-operative evolution. She had no other medical nor surgical history. This patient contracted her first pregnancy spontaneously four years after her enterocystoplasty, the follow-up of her pregnancy did not reveal any particular abnomalitly, an indwelling bladder catheter was put after consultation with the urologist at 34GW. A caesarean section was indicated , which was performed in the presence of the urologist We performed a medial laparotomy incision under umbilical, we released some parieto-epiploic adhesions to finally access the intraperitoneal space. The exploration finds the surgical assembly of iléo-cystoplasty resting on the uterus, covering the uterine body by the intestinal loops and the mesometer, the neovessie was located at the physiological location of the bladder, opposite the lower segment, adherent in the latter, the ureters were not easily localized, and we did not find any interest in locating them (with the risk incurred during the dissection) We tried to take off the neo-bladder to have access to the lower segment, but given the adhesions we prefer to access the uterus at the corporeal level by pushing all the surgical assembly to the right side which included the most adhesions. The adhesiolysis was performed hemostatically, the uterine approach allowed us to make the vertical corporal incision without problems and extract an eutrophic newborn with an Apgar score of 10.

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Discussion:-

Pregnancy on replacement enterocystoplasty is a very rare clinical case, for our patient, this surgical assembly was performed by laparoscopy for the treatment of leo-sarcoma of the bladder. 193 cases of LMS have been described in the literature, it preferentially affects the male sex with a sex ratio of 3/1 [1,2], which makes the rarity of pregnancies on a similar pathology The treatment of bladder LMS is mainly surgical. It is based on a partial cystectomy, for small superficial tumors [3] and a radical cysto-prostatectomy in men or anterior pelvectomy in women in case of infiltrating tumors. [4]

In our patient she benefited from a total cystectomy sparing the internal genital organs, considering the field (single without child) and seen her young age (aesthetic point of view), the laparoscopic route was preferred, and a replacement enterocystoplasty was realized.

The follow-up in this case is multidisciplinary, considering the general urological changes during pregnancy:
The gravid uterus is responsible for a deformation of the bladder with enlargement of the base and change of curvature of the trigon which becomes convex [5] as well that the intra-abdominal hyperpression caused by the increase in the volume of the uterus exerted on the bladder, the increase in the total length of functional urethra, the increase in intra-vesical pressure from 9 to 20 cm H2O and an increase in urethral closing pressure. [6]

On the other hand, the hypotonicity of the excretory path constitutes a favorable ground for microbial proliferation [7], especially in the case of our patient, where bladder emptying is not optimal, as in the case of native bladders.

All this, associated with sphincter disorders, is an indication to place a bladder catheter from a more or less advanced gestational age, for our patient it was set at 34SA The vaginal delivery is not formally contraindicated but carries risks of neo-bladder trauma as well as postpartum incontinence

In addition, enterocystoplasty complicates caesarean section, some authors recommend performing MRI to identify pelvic anatomical changes

The postoperative course was normal.

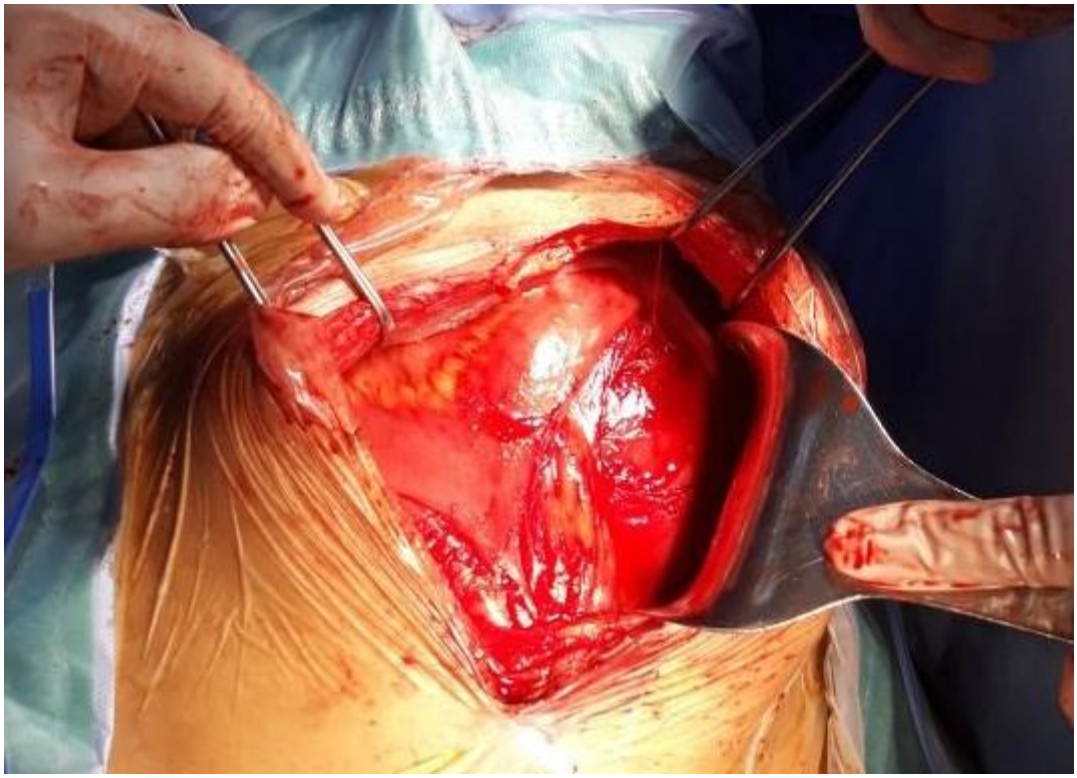

Figure 1:-the surgical assembly, enterocystoplasty

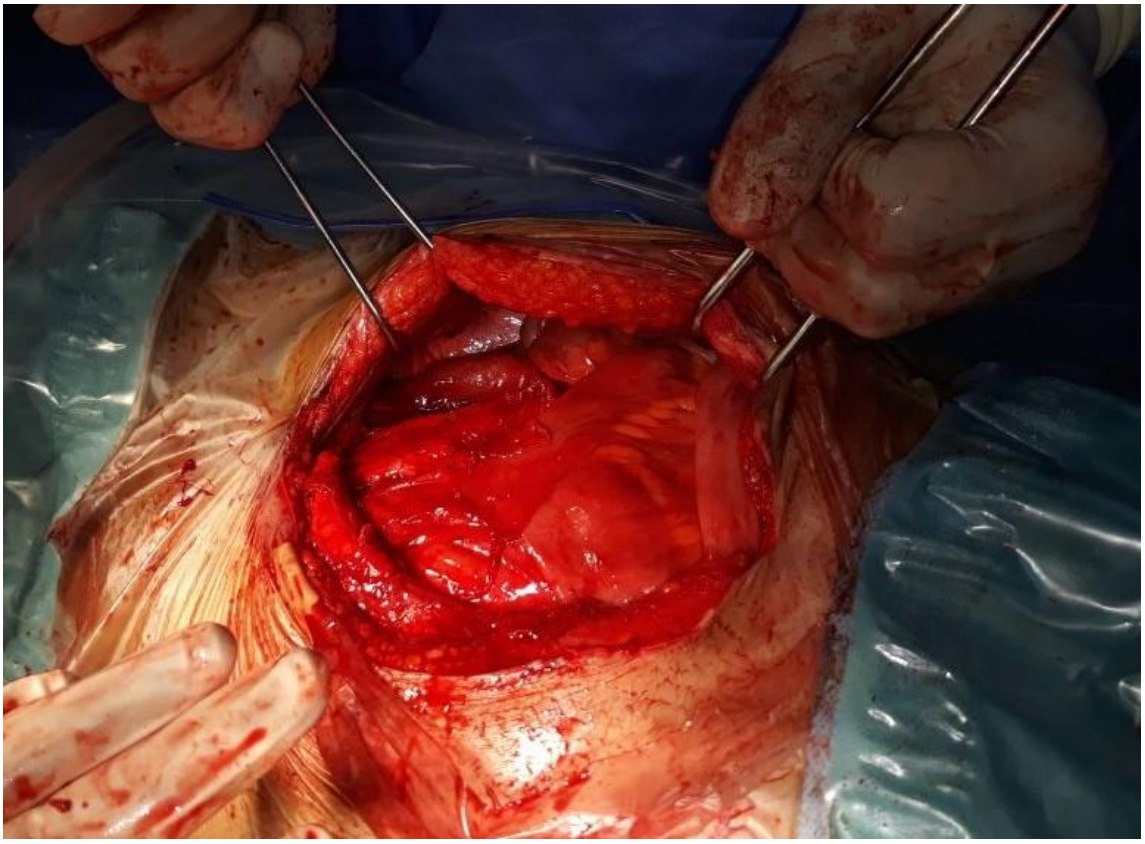

Figure 2:-the surgical assembly, enterocystoplasty : view of a different angle

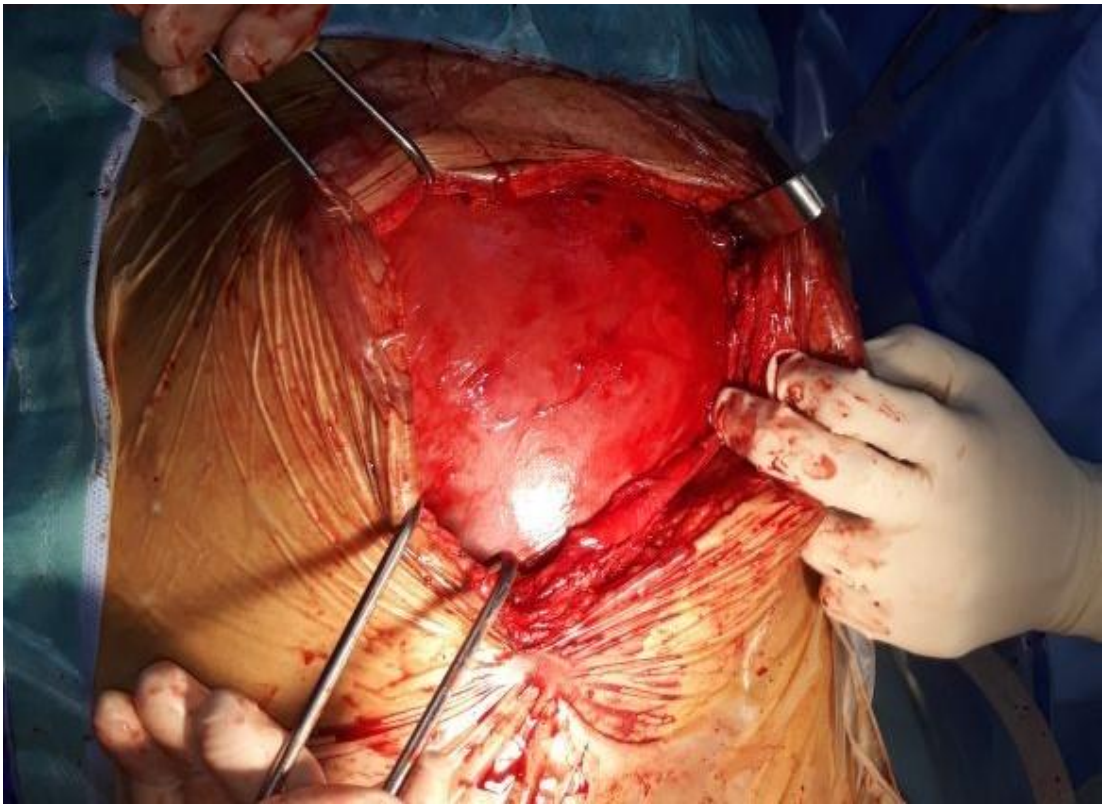

Figure 3:-the uterus at the corporeal level, the surgical assembly is pushed to the right side

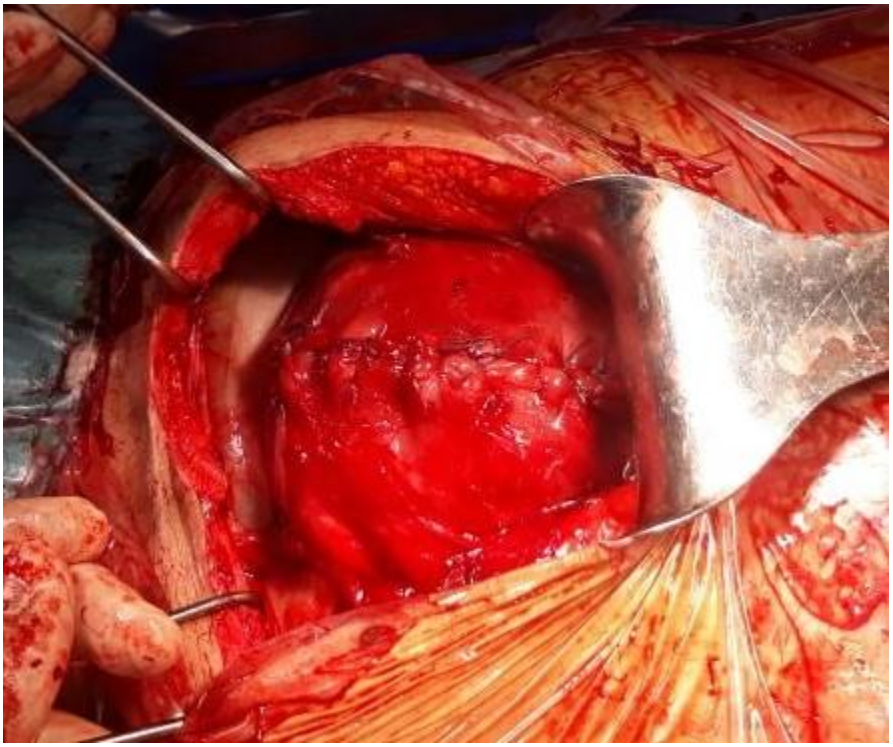

Figure 4:-the uterus after the extraction.

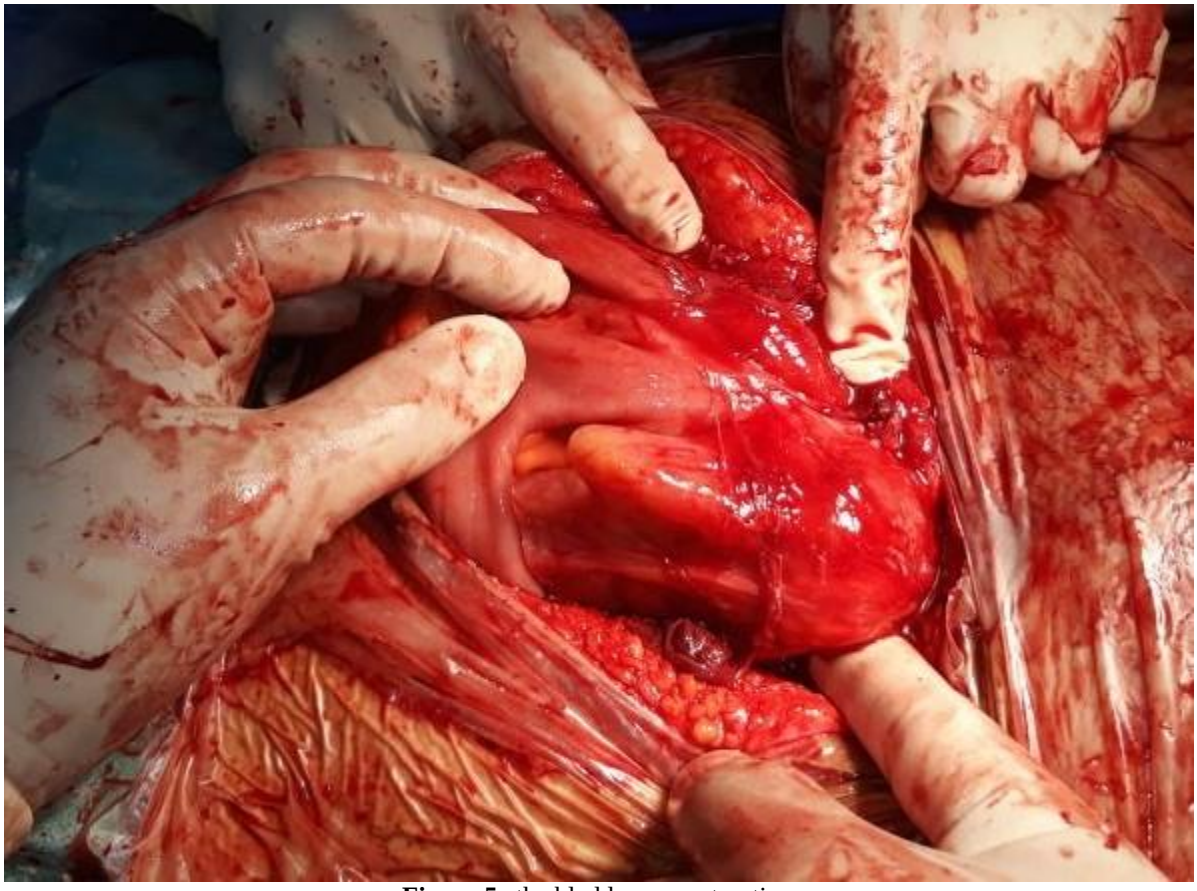

Figure 5:-the bladder reconstruction

Conclusion:-

Prenatal monitoring and preparation for pregnancy for patients with bladder repair is essential to avoid the complications that may occur during pregnancy, to make the prognosis of childbirth, and for an uncomplicated evolution in the post –partum

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Declaration:-

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Conflict of interest: None

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