



WATERBALLON UNDER THE BRIDGE – A RARE CASE REPORT OF SCROTAL CYSTOCELE.

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Abstract:

Scrotal cystocele, commonly known as a complete herniation of the urine bladder into the scrotum. Most of the people who have had it reported are older, and they frequently have obstructive symptoms. Scrotal cystocele, or inguino-scrotal herniation of the bladder, is extremely an uncommon yet clinically significant disease that if ignored preoperatively. We discuss the characteristics of scrotal cystocele on computed tomography and magnetic resonance imaging, as well as the radiologic findings of this uncommon condition that have been reported in the literature.

Keywords:

Urinary Bladder, Scrotum, Hernia, CT, MRI.

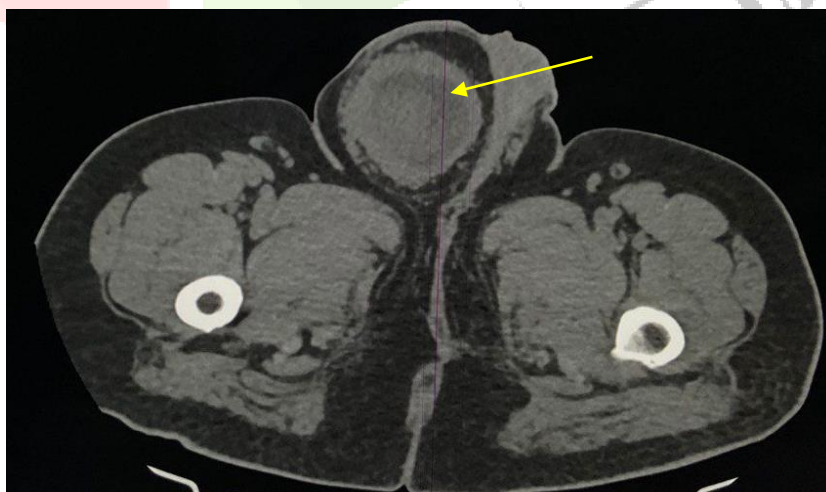
Introduction:

In 4% of cases, inguinal hernia patients had urinary bladder involvement ^[1]. Scrotal cystocele or a large expansion of the bladder into the scrotum, is extremely uncommon. Different symptoms may appear. There will likely be some voiding problems in the majority of patients. But while some individuals will stay asymptomatic, others will show signs of renal failure, sepsis, or bladder necrosis ^[2,3,4] obturator, suprapubic,

ischio-rectal regions are a few more locations where herniation can develop.^[5] We report a case in this literature who incidentally presented with urinary symptoms with large right sided inguino-scrotal hernia. A significant scrotal cystocele was discovered during an investigation of his voiding symptoms.

Case report:

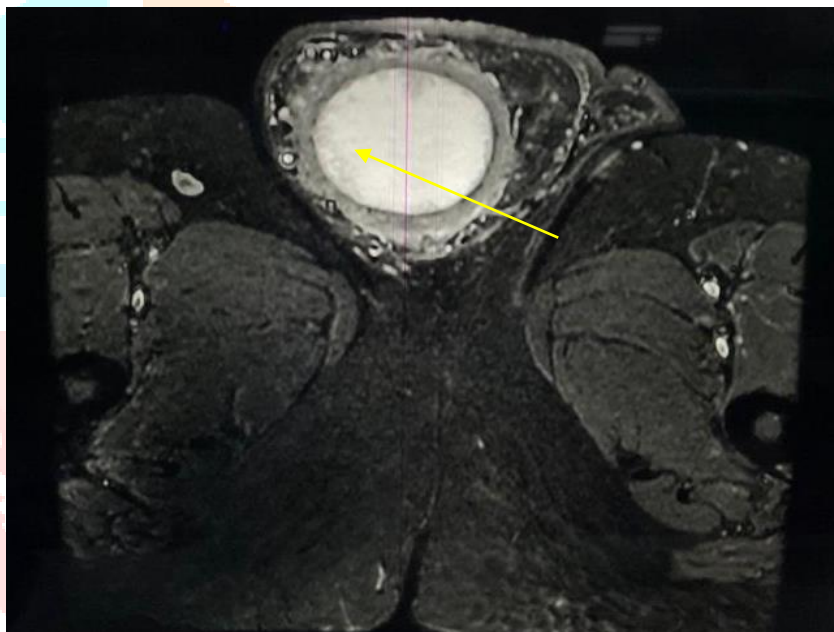
A 50-year-old man with a fistula-in-ano was hospitalised, and when he visited for an evaluation of his MRI fistulogram, we unintentionally discovered that he had right scrotal swelling. This enlargement appeared to correspond to the patient's complaint of difficulty voiding and a slowing of the urinary stream over a 15-year period. He had no prior history of prostatitis, prostatomegaly, venereal infections, or inguinoscrotal injuries. A moderately obese man with a noticeable right inguino-scrotal mass was identified during a physical examination. The contents of the contralateral hemiscrotum were examined, and it was discovered that the testis was regularly descending and that there was no sign of an inguinal hernia, varicocele, or concomitant hydrocele. Complete blood count, blood chemistry, urine analysis, and urine culture were all normal results from the lab. Even though CT is not the most common way to diagnose bladder hernias, it is possible that clinically undiagnosed instances may be examined as part of gastrointestinal or urologic complaints. On cross-sectional imaging, the radiologist should be able to identify the characteristics of scrotal cystocele. CT Axial and Sagittal section showed that the bladder's outline was asymmetric, with the anterior inferior side of the bladder angling toward the inguinal ring (Figure -1) a substantial inguino- scrotal bladder herniation was visible on further pictures through the scrotum(Figure-2). MRI Axial T2 STIR and SAG T2 STIR images (Figure 3 & 4) revealed, a right inguino-scrotal hernia with urinary bladder and bilateral distal ureters as herniating contents, because contralateral ureter may be moved anteriorly by traction on the bladder and causing moderate upstream dilatation and bilateral mild hydrocele.



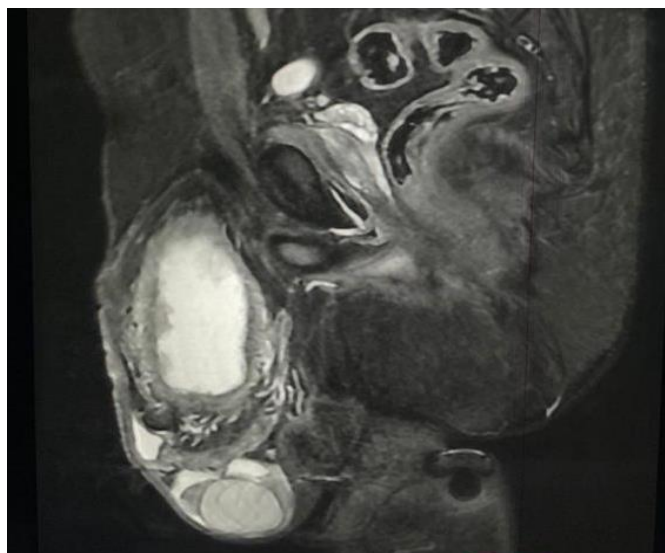
(Figure-1) CT AXIAL SECTION



(Figure-2) CT SAGGITAL SECTION



(Figure -3) - AXIAL T2W STIR



(Figure-4) SAGITTAL T2W STIR

Discussion:

Any pelvic or lower abdominal orifice might allow the bladder to herniate; femoral hernias and direct or indirect inguinal hernias are the most frequent. The pathophysiology of bladder herniation has been linked to obesity, urinary outlet obstruction caused by prostatitis, prostate enlargement, contracture of the bladder neck, and urethral obstruction, loss of bladder tone, and weakening of the supporting tissues in elderly people. Most bladder hernias are clinically unsuspected. Symptoms include biphasic voiding (the first occurs naturally and the second is induced by manual pressure on the hernia) and other voiding complaints related to bladder outlet obstruction or urinary tract infection such as nocturia, urgency, difficulty in voiding, hematuria. Sometimes it is stated that the hernia shrinks following urination. Hydronephrosis, Malignancy, vesico-ureteric reflux, perforation and strangulation is one of the complications of this illness that has been documented.^[6,7] Urography or cystography are often used to identify small, unrecognised bladder herniation or big, symptomatic scrotal cystoceles.^[8,9] The radiological trinity was defined by Reardon and Lowman as follows: inadequate visibility of the vesical base, asymmetrical bladder and lateral displacement of the distal third of one or both ureters.^[10] An anterior/inferior side of the bladder that is angled and points anteriorly towards inguinal ring and extends into inguinal canal and scrotum is readily visible on a CT scan and MRI scan shows a right inguino-scrotal hernia with the urine bladder and both distal ureters protruding, since the contralateral ureter may be pulled anteriorly by the bladder, resulting in moderate upstream dilatation and bilateral mild hydrocele. In addition to enabling the identification of this condition CT and MRI also have the ability to spot some of its previously described consequences.^[11,12]

Conclusion:

Inguinal hernias may include the bladder, although significant bladder herniation into the scrotum is extremely uncommon. Computed tomography and magnetic resonance imaging have only been used to study a small number of these instances. We provide the CT and MRI characteristics of a patient's scrotal cystocele and discuss the radiologic findings of this uncommon condition that have been documented in the literature.

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