



Medical Imagery

Incidental pseudolymphomatous bladder inflammatory polyp revealing urinary schistosomiasis



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SUMMARY

A 25-year-old female who had returned from a trip to Madagascar that was not reported, underwent an endoscopic bladder polyp resection. Histopathology examination revealed an intense pseudolymphomatous inflammatory polyp caused by a *Schistosoma* infection. Bladder polyps due to schistosomiasis represent a rare condition in developed countries and have to be ruled out in the case of any intense unexplained inflammation.

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Figure 1. B-mode pelvic ultrasonography showing a 14-mm perimeatal bladder polyp.

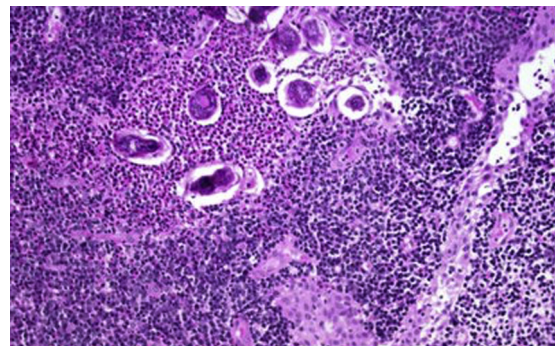


Figure 2. Histopathological section of the bladder polyp revealing *Schistosoma* ova and tissue inflammation (hematoxylin–eosin stain, original magnification $\times 100$).

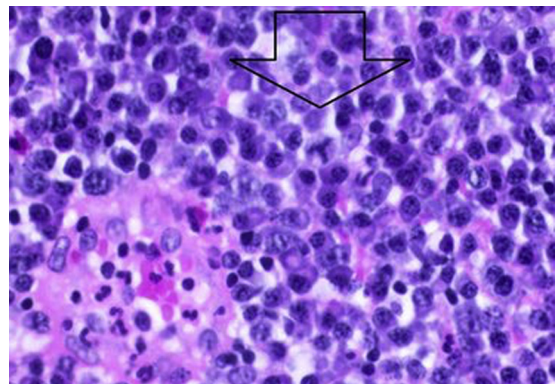


Figure 3. Abnormal mitosis with tissue inflammation mimicking lymphoma (hematoxylin–eosin stain, original magnification $\times 200$).

A 25-year-old female with a medical history of uterine leiomyoma, who was a cigarette smoker, was diagnosed with a 14-mm perimeatal bladder polyp during an ultrasonography examination performed as part of her routine gynecological follow-up (Figure 1). The patient had not experienced gross hematuria or dysuria. However, urinalysis revealed microscopic hematuria. She subsequently underwent a transurethral bladder polyp resection.

Histological examination revealed an intense pseudolymphomatous inflammatory polyp with eosinophils surrounding viable *Schistosoma haematobium* ova, consistent with an acute infection (Figure 2). The presence of morphologically abnormal mitosis raised the possibility of a lymphoma (Figure 3), which was ruled out by the presence of parasitic structures and a reassuring immunochemical profile. Serological testing for schistosomiasis was positive. Unfortunately, a urine examination for parasites was not performed. Further anamnesis revealed that the patient was a Malagasy native and had returned from a trip to Madagascar 6 months previously. Schistosomiasis is endemic in Madagascar.¹ A course of praziquantel (40 mg/kg) was prescribed, to which the patient responded.

Cystoscopy of acute *S. haematobium* infection usually reveals tubercles and nodules.² Polyps are also a common ultrasonographic feature.³ *Schistosoma*-induced polypoid lesions are more frequently observed in the younger population and regress with praziquantel treatment.⁴

This report indicates that urinary schistosomiasis should be ruled out in any patient, symptomatic or not, who presents with urinary tract abnormalities combined with a history of immigration from, or stay in, or travel across, areas known to be endemic for this helminthiasis. Due to the recent emergence of *S. haematobium* in Corsica,⁵ Metropolitan France should be added to this list.

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