



AN UNUSUAL FOREIGN BODY IN BLADDER FOR 25 YRS – A CASE REPORT

Dr. Jyotirmaya Nayak	Asst professor, Dept of General Surgery , SCB Medical College And Hospital, Cuttack
Dr. Rasmi Kanta Patra	MD. (O&G),Laparoscopy Surgery &Infertility Consultancy.
Dr. Pratyush Kashyap Panda	Post Graduate Student, Dept Of General Surgery, Scb Medical College And Hospital
Dr. Asish Ku Behera	Post Graduate Student, Dept Of General Surgery, Scb Medical College And Hospital
Dr. Chinmayee Jena	Medical Officer , Sai Hospital , Kendrapada
Dr. Yashoda Jiban Senapati	Under Graduate Student Scb Dental College And Hospital

ABSTRACT

Rationale: Foreign bodies in urinary bladder has been a topic of interest in recent times mainly among the general surgeons and urologists. Intravesical and intraurethral foreign bodies are usually due to self-insertion, sexual assault, iatrogenic trauma. . Many patients present with obstructive and irritative LUTS symptoms like hematuria,urgency,frequency,Chronic lower abdominal pain, urine retention etc. **Case Presentation:** A 30-year-old female presented with complaints of vague lower abdominal pain for last 7 days,With a history of C section 2 weeks back for her 2nd live birth. **Diagnosis:** Ultrasound of the abdomen revealed a foreign body inside urinary bladder of size 11 x 1.2 cm. **Treatment:** The foreign body was removed under cystoscopic guidance. A pen of size 11 cm was detected inside the bladder and was removed without any surgical or post surgical complications. **Conclusion:** Bladder is the usual site for a foreign body to be lodged when presented. So the main aim for intervention should be complete retrieval of foreign body with minimal damage to organs and preferably with minimal access.

KEYWORDS :**INTRODUCTION**

Foreign bodies in urinary bladder has been a topic of interest in recent times mainly among the general surgeons and urologists. In cases with LUTS, foreign bodies represent an uncommon finding. Intravesical and intraurethral foreign bodies are usually due to self-insertion,sexual assault, iatrogenic trauma, migration from nearby sites but is rare.Self insertion has been associated with dementia and other psychiatric abnormalities. Many objects have been detected in urinary bladder like pencil, bullets, magnets, thermometers, mobile phone charger,orthopedic implants, batteries, IUCDs etc.Those who insert foreign bodies for sexual gratification present late, due to embarrassment and guilt. In children ,curiosity is the main reason for self-insertion of foreign body in urethra.The length of time a foreign body remains in bladder without causing any symptoms can vary within very wide limits. So in many cases a foreign body may remain inside the bladder without getting encrusted with salts and without causing any symptoms. In Others foreign bodies are rapidly coated with urinary salts and become completely encrusted. The reason behind this is not always clear. Perhaps smooth bodies resist encrustation as compared to the rough ones. The time of onset of infection in the bladder is the most important factor and in many cases depends upon the local trauma caused by the foreign body upon the vesical mucosa of the bladder. A foreign body which is fixed will cause more local trauma than an object which is freely movable. Many patients present with obstructive and irritative LUTS symptoms like hematuria,urgency,frequency,Chronic lower abdominal pain, urine retention etc. Rarely patients can develop complications like hydronephrosis, perforation of bladder,renal failure. Physical examination usually reveals no significant findings but urine microscopy shows pus and red blood cells.Radio opaque objects can be detected with plain x ray,others can be detected via Ultrasound of the

abdomen. Cystoscopy can identify the object with its position in the bladder. With advances in endoscopy open surgery usually not required. Cystoscopy has both diagnostic and therapeutic uses for LUT foreign bodies. Foreign bodies can be removed successfully using grasping forceps. Small bodies are removed intact but larger foreign bodies may need fragmentation. Some foreign bodies can be found in the dome of bladder because of their density so cystoscopic retrieval is done carefully. Patients with retained renal foreign bodies can be retrieved using retrograde endoscopic techniques. Foreign bodies in upper tracts can pose a challenge in retrieval so they may need direct visualization. There is a marked preponderance among male patients when it comes to self-insertion but rarely seen in females.Here we report an unusual case of a linear foreign body in bladder that was present for 25 years without any symptoms was successfully retrieved cystoscopically under general anesthesia.

CASE PRESENTATION

A 30-year-old female presented with complaints of vague lower abdominal pain for last 7 days. She gave a history of C section done 2 weeks back. A physical examination revealed mild tenderness in suprapubic region. No other findings were revealed on abdominal examination. Complete blood count and electrolyte profile were normal. An ultrasound of the abdomen revealed a foreign body inside urinary bladder of size 11 x 1.2 cm(Fig1).After enquiring she gave a history of insertion of a foreign body per urethra when she was 14 years old.

The foreign body was removed under cystoscopic guidance (fig 3) and a pen of size 11 cm was detected inside the bladder and was removed(Fig2) with no surgical or any post-surgical complications with normal psychiatric evaluation patient and was discharged after 2 days.



Fig 1



Fig 2



Fig 3

DISCUSSION

Bladder is the usual site for a foreign body to be lodged when presented. Mostly patients present with a chief complaint of urinary retention, dysuria, hematuria, increased micturition, priapism among males, pain in urethra and pelvis. It can sometimes be challenging in diagnosing such cases and managing as well. Two third of cases of foreign body in urinary bladder are transported following self-insertion in urethra. Mostly it is done for sexual stimulation and mainly by mentally retarded. It is very difficult for a man to self-insert an object into urethra due to anatomy of lower urogenital tract. If it is done then it is mostly due to sexual gratification. In children, curiosity and inquisitiveness found to be the main reason for foreign body insertions. Foreign bodies like pencils, telephone cables, thermometers, glass rods, candles, fruit kernels, have been removed from the bladder and urethra. Most of these foreign bodies can be removed transurethraly with the help of minimal access techniques. Other case series like pec et al reported case series of 23 men having urethritis with gangrene of external genitalia and sepsis due to insertion of foreign body in through urethra. Keeping catheter for long term is associated with bladder stone formation and self-removal of catheter can lead to retaining of catheter tip or balloon in the catheter presenting with foreign body in bladder. Removal of foreign bodies can be done with the help of endoscopic procedures and if needed with open surgery depending on the location of foreign body. Foreign bodies found above urogenital diaphragm can be removed easily with endoscopes but above it may require endoscopic manipulation and open surgeries. In the present case patient forcefully inserted a pen into her urethra and was transported to bladder. Therefore in cases of foreign bodies in bladder the aim and objective for intervention should be removal of foreign body as a whole as retained parts of foreign bodies can further complicate the situation. This can be done by either endoscopic or open procedures. To avoid recurrence of such cases a psychiatric evaluation must be done as recurrent self-infliction of foreign bodies can lead to sepsis and gangrene of external genitalia which is life threatening to the patient.

CONCLUSION

Therefore in this case the foreign body was found to be a pen which was retrieved successfully without any difficulty. So the main aim for intervention should be complete retrieval of foreign body with minimal damage to organs. Foreign bodies can range from easily available objects. Such cases require prompt evaluation and removal. A psychiatric evaluation is a must for such patient and patients should be counselled about the complications with such acts and should never be repeated.

REFERENCES

1. T. Sukkarieh, M. Smaldone, B. Shah Multiple foreign bodies in the anterior and posterior urethra Int. Braz. J. Urol., 30 (2004), pp. 219-220
2. P. Ejstrud, J. Poulsen Laparoscopic removal of an electric wire from the bladder Br. J. Urol., 80 (1997), p. 338
3. N.J. Andrews, C.N. Hall, T.V. Taylor Colovesical fistula caused by a chicken bone Br. J. Urol., 62 (1988), p. 617
4. D. Potter, D. Smith, A.J. Shorthouse Colovesical fistula following ingestion of a foreign body Br. J. Urol., 81 (1998), pp. 499-500
5. K. Nishiyama, T. Shimada, S. Yagi, M. Kawahara, M. Nakagawa Endoscopic removal of intravesical thermometer using a rigid nephroscope and forceps Int. J. Urol., 9 (2002), pp. 717-718
6. A. Gulanikar, P. Pandey, F. Terrell A bullet in the bladder Br. J. Urol., 82 (1998), p. 304
7. T.A. el-Diasty, A.A. Shokeir, M.S. el-Gharib, L.S. Sherif, M.A. Shamaa Bladder stone: a complication of intravesical migration of Lippes loop Scand. J. Urol. Nephrol., 27 (1993), pp. 279-280
8. N.D. Forester, C. Evans, D.F. Thomas, A. Najmaldin Bladder stones associated with synthetic absorbable sutures in children BJU Int., 88 (2001), p. 984
9. H.C. Ward Surgical staples in bladder calculi after caecocystoplasty Br. J. Urol., 60 (1987), p. 375
10. W. Kochakarn, W. Pummanagura Foreign bodies in the female urinary bladder: 20-year experience in Ramathibodi Hospital Asian J. Surg., 31 (2008), pp. 130-133
11. T.Y. Lin, C.K. Chuang, Y.C. Wong, H.C. Liao Gossypiboma: migration of retained surgical gauze and spontaneous transurethral protrusion BJU Int., 84 (1999), pp. 879-880
12. S.D. Eckford, R.A. Persad, S.F. Brewster, J.C. Gingell Intravesical foreign

- bodies: five-year review Br. J. Urol., 69 (1992), pp. 41-45
13. G. Habermacher, R.B. Nadler Intravesical holmium laser fragmentation and removal of detached resectoscope sheath tip J. Urol., 174 (4 Pt 1) (2005), pp. 1296-1297
 14. K.A. Hutton, S.N. Huddart Percutaneous retrieval of an intravesical foreign body using direct transurethral visualization: a technique applicable to small children BJU Int., 83 (1999), pp. 337-338
 15. A. Van Ophoven, J.B. deKernion Clinical management of foreign bodies of the genitourinary tract J. Urol., 164 (2000), pp. 274-287
 16. M. Rafique Intravesical foreign bodies: review and current management strategies Urol. J., 5 (2008), pp. 223-231
 17. D.K. Pal Intravesical foreign body Indian J. Surg., 61 (1999), pp. 381-383
 18. S.D. Eckford, R.A. Persad, S.F. Brewster, J.C. Gingell Intravesical foreign bodies: five-year review Br. J. Urol., 69 (1992), pp. 41-45
 19. J. Pec, S. Straka, F. Novoesky, F. Novomesky, J. Khiment, M. Pec, et al. Mechanical urethritis and ascendant genitourinary infection due to sexual stimulation of the urethra by inserted foreign bodies Genitourin. Med., 68 (1992), pp. 399-400
 20. R.D. Kenney Adolescent males who insert genitourinary foreign bodies: is psychiatric referral required? Urology, 32 (1988), pp. 127-129
 21. H. Aliabadi, A.S. Cass, P. Gleich, C.F. Johnson Selfinflicted foreign bodies involving lower urinary tract and male genitals Urology, 26 (1985), pp. 12-16
 22. R.A. Aghe, A.J. Fowler, A. Saetta, I. Barai, Rajmohan, D.P. Orgill, The SCARE Group The SCARE statement: consensus-based surgical case report guidelines Int. J. Surg., 34 (2016), pp. 180-186