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Surgery

SELF INSERTED FOREIGN BODIES IN URETHRA FOR AUTO EROTISM: A RARE PRESENTATION & SUCCESSFUL REMOVAL

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ABSTRACT Self-inserted urethral foreign bodies are rare but usually emergencies situation that general surgeons may face. Most foreign bodies in the lower genitourinary tract are self-inserted via the urethra as the result of autoerotism, sexual curiosity, and sexual practice while intoxicated and in person with psychometric problems. Clinical history, physical examination, and image studies of the patient are the basis of diagnosis of these foreign bodies. Management depends on the Location, shape, size, and mobility of foreign bodies. Minimally invasive procedures such as endoscopic removal are recommended to prevent bladder and urethral injuries. In some cases, surgical treatment should be done if the foreign bodies cannot be removed by the endoscopic procedure or further injuries are expected as a result of the endoscopic procedures. In our case also foreign body removed surgically however effort was made by endoscope.

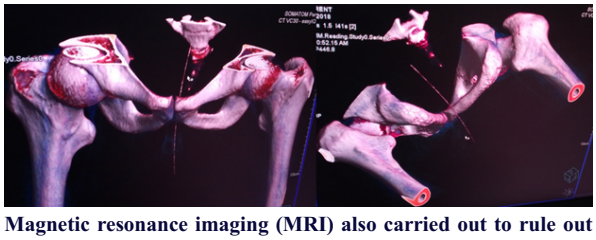
KEYWORDS : Urethra, Foreign bodies, Endoscopy, Surgical treatment

INTRODUCTION

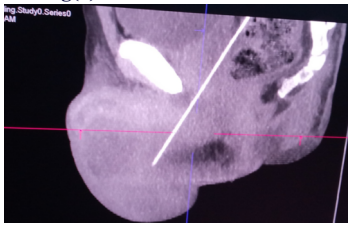
The insertion of foreign bodies into the urethra is an unusual scenario, but many cases have been reported. It has seen during pathological masturbation, intoxication, curiosity, autoerotic stimulation, underlying psychiatric condition or for medical procedures. The foreign body may disappear into the urethra or sometime it may visible at the urethral meatus[1]. Variety of foreign bodies that are inserted in urethra such as telephone cables, metal roads, hairpins, screws, pellets, wires, wooden sticks, piece of fish, and fish hooks [2-4]. Usually patients delayed presentation due to shame, social stigma and guilt. The foreign body can remain for a long time with minimal discomfort. However, the foreign body causes severe pain, hematuria, and urinary tract infection in the most cases, [5]. Generally patient present with dysuria, urinary frequency, hematuria, suprapubic pain, swelling of the penis and external genitalia and abscess formation[6]. Diagnosis is done by history and careful clinical examination. Radiological and cystoscopy examinations are required for diagnosis and management [7]. The management should include foreign body removal and prevention of long-term complications, alongwith evaluation of patient's motive and psychiatric consultation. Foreign bodies should be remove carefully and procedures should be as simple as possible that will cause minimal damage to the bladder and urethra[1].

CASE SUMMARY

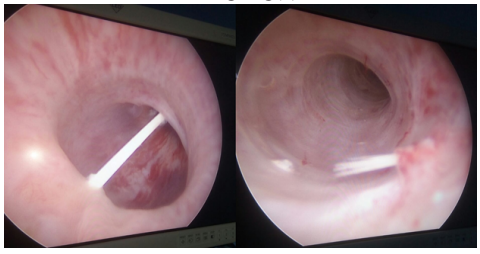
A 25 year unmarried male presented to us with complain of scrotal pain. On examination there was tenderness present on right side of base of scrotum. Ultrasonography carried out which was suggestive of periurethral abscess with suspicion of foreign body, but patient was denying for same. Then patient attendents enquired for any psychiatric illness of patient, but they also denied for the same. We did computed tomography scan (CT scan), it was showing foreign body at base of penis upto anterior wall of rectum.fig (1).



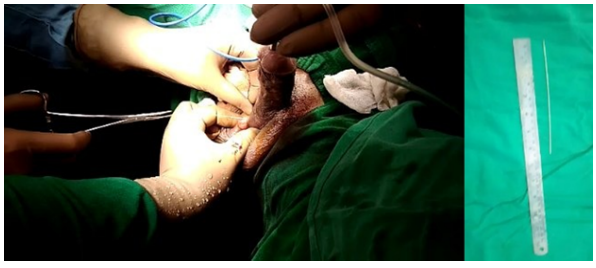
Magnetic resonance imaging (MRI) also carried out to rule out rectal perforation. fig(2)



Then patient planned for cystoscopy and removal under regional anaesthesia, but retrieval could not attempted due to horizontally fixation and fear of urethral damage.fig(3)



So incision given at indurated region, foreign body palpated and extracted out with artery forceps which was plastic rod around 25cm in length and 3-4 mm in diameter.fig(4)



foley's catheter 16 fr placed in urethra after removal of foreign body and kept for 1 week. After removal of foley's catheter asked for psychiatric consultation but he refused. He is doing well three month of follow up.

DISCUSSION

The incidence of insertion of foreign bodies into the urethra is very rare condition. However In the literatures many case reported and a lot of types of self inserted foreign bodies are mentioned, such as telephone cables, rubber tubes, feeding tubes, straws, string, toothbrushes, household batteries, light bulbs, marbles, needles, pencils, ball point pens, pen lids, garden wire, copper wire, speaker wire, safety pins, Allen keys, cotton tip swabs, plastic cups, thermometers, plants and vegetables (carrot, cucumber, beans, hay, bamboo sticks, grass leaves), parts of animals (leeches, squirrel tail, snakes, bones), toys, pieces of latex gloves, blue tack, intrauterine contraceptive devices, tampons, pessaries, powders , and fluids (glue, hot wax)[8-10]. The most common reason for self insertion of a foreign body into the male urethra is for autoerotism, especially during, masturbation[2,4,11].Majority of patient's treatment delayed due to delayed presentation, because of guilt, social stigma, and humiliation. This leads to multiple self removal attempts, which can cause urethral injury and foreign body migration. Many cases reported with psychiatric disorders [2, 4]. Drug intoxication,[2,4]

mental confusion,[12] sexual curiosity or autoerotism.[2,4,11] Lack of partner or spouse and misconception about masturbation are also causing factors. The most prevalent factor for self-insertion of urethral foreign bodies is autoerotism.[2,4] Psychiatric conditions reported in patients with exotic impulses, a disturbed schizoid personality and borderline personality disorder.[11] In a retrospective analysis by Reider et al. in which 8 of 13 (61%) individuals investigated, self-inserted secondary to autoerotism.[4] our case also fit in this scenario. Urethral foreign bodies usually migrate into the bladder by being pushed further into the urethra to remove them or by involuntary perineal muscle contraction. Urethral self-insertion of foreign bodies may be complicated when the inserted object migrates to the proximal urethra or bladder and cannot be retrieved[4]. In our case it was pierced through urethra and lies above the anterior rectal wall. With careful history taking and physical examination, physicians can get information about the type of foreign body and duration of insertion. Usually the diagnosis is confirmed on physical examination. Foreign bodies distal to the urogenital diaphragm are easily palpable. A X-ray pelvis and computerized tomography of the abdomen and pelvis can be useful in defining a foreign body's position, orientation, relationship to surrounding viscera. [9] Physical nature and morphology of foreign body are important factor for the planning of the method of removal. The aim should be minimize trauma and preserve erectile function. Endoscopic methods with the aid of forceps, snares, and baskets, and as such have become the standard of care for foreign bodies located distal to the urogenital diaphragm. [8, 9] Cystourethroscopy has to be done to diagnose any urothelial injuries and to ensure complete removal of foreign bodies. Features of safe removal of these items include cooling the metal object with ice to prevent tissue heating, protecting the patient from sparks, and protecting the penis from the cutting blade.[2,4] More invasive foreign body extraction procedures are required rarely, like – external urethrotomy, suprapubic cystotomy, or meatotomy.[8,13] Complications following these procedures are rare but can include infection, incontinence ,fistula, urethral stricture and diverticulum.[8,9,13] urethral strictures are the most common delayed complication (5% incidence).[8] Thus, regular follow up is required for early diagnosis of the complications. However, it is important to get done psychiatrist consultation to know the probable causes for this behavior by, so that counseling and treatment in total can be done to prevent a repetition of the episode.

There are a few psychoanalytical theories postulated on the references, analyze the cause. Review of various articles mentions the following contributing factors, which may lead to self-introduction of foreign bodies.

- Accordimg to Kenney's theory the initiating event is an accidentally discovered pleasurable stimulation of the urethra, which is followed by repetition of this action using objects of unknown danger, driven by a particular psychological predisposition to sexual gratification.[14]
- Mitchell developed the psychiatric theme (feminine identification) that intraurethral insertions expressed feminine identification and denial of the maleness. The patient does not want to insert the penis but prefers some object to be inserted in the penis.[14]
- Urethral manipulation is a paraphilia combining sadomasochistic and fetishist elements where the orgasm of the individual depends on the presence of the fetish. He believed it showed a regression to a urethral stage of eroticism due to a traumatic event or a strong libidinal drive according to Wise .[15]
- Craissati J et al. states arousal behavior is that behavior which accompanies or promotes genital excitement. In the chain of events beginning with sexual arousal starts with sexual contact or stimulation of some kind. Urethral masturbation wherein the person introduces objects on multiple occasions in the urethral opening for sexual gratification is another reason. However, medical help is taken only when the object gets stuck.[6,16]
- In sadistic sexual abuse, the person incites or tries to incite a feeling of pain in him or a partner/victim to increase the sexual pleasure. The various method described are the insertion of foreign bodies, use of weapons and restrains.[16]
- Intoxication and subsequent intoxicated sex play can lead to the foreign body insertion.[17]
- Hausserman cites a case report of a patient with dementia of Alzheimer's type who repeatedly inserted foreign bodies in the penis. Older patients with dementia are known to have increased sexual activity.[18]
- The most prevalent motivation is autoerotism for self-insertion of urethral foreign bodies.[8,9] Some cases are reported with practice under the influence of intoxicating substances, mental and cognitive disorders, factitious disorders, personality disorders, sexual curiosity.[9,19] Iatrogenic and accidental foreign bodies occurs rarely.[20] Mode of its extraction dpends upon morphology and position foreign body and often can be done endoscopically. Foreign body extraction is can often be successfully achieved endoscopically. However, a more multidisciplinary approach to management is crucial, which includes not only the prevention of infection, prevention of further urethral injury, assessment and documentation of more associated injury,and monitoring of delayed complications. Motivational and psychosocial issues should be taken care of to prevent future episodes.

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