Large Vesical Diverticulae with Narrow Neck, Presenting with Features of Severe Urinary Tract Infection Managed Surgically

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Abstract A case of multiple large urinary bladder diverticulae, with narrow neck, presented with features of severe urinary tract infection, with increased frequency of micturition, not treated since a long time. The muscular dehiscence that is at the origin of a diverticulum may be either congenital or degenerative. Two important complications of the diverticulum—that are sometimes interwoven—may occur: a draining defect and the development of an urothelial tumour in the diverticulum cavity. For such complicated diverticula, surgery is indicated. Results may be excellent, provided the surgical intervention focuses at the same time on the management of the associated subvesical obstacle in case of an acquired diverticulum.

Keywords Bladder diverticulae · Urinary tract infection · Cystoscopy · Diverticulectomy

Case Report

A 22-year-old male presented to us with frequent attacks of low-grade fever, recurrent urinary tract infection and increased frequency of micturition since last 10 years. He underwent ultrasonography which revealed multiple large bladder diverticulae containing infected urine. Intravenous urography was done. There was no hydroureteronephrosis. Voiding film

Fig. 1 Large vesical diverticulum dissected from surrounding structures

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Fig. 2 Internal opening of the large capacity diverticulum

revealed multiple diverticulae. Post-void film showed persistently filled large diverticulae.

Cystourethroscopy was done. Three large diverticulae with narrow necks were negotiated, these diverticulae were found to be filled with infected urine and pus flakes.

Both ureteric orifices were identified close to the neck of the diverticulae and bilateral ureteral stenting was done before surgery. During surgery all the bladder diverticulae were separated from the surrounding structures, namely, rectosigmoid colon, external iliac vessels and surrounding bladder wall (Fig. 1).

The narrow necks (Fig. 2) were closed with vicryl. Post-operative phase was uneventful. Follow-up cystoscopy after 3 months revealed a normal capacity bladder with normally placed ureteric orifices.