CASE REPORT

Foreign body urethra misdiagnosed as stricture leading to inadequate management and prolonged treatment duration: a lesson to learn

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SUMMARY

Misdiagnosis of a urethral foreign body (FB) as urethral stricture leads to inadequate management and prolonged treatment duration. A 55-year-old male patient was referred with complaints of difficulty in voiding and poor urinary stream for 2 months. He initially presented at a primary healthcare centre and was misdiagnosed as urethral stricture and was scheduled for urethroplasty. Surprisingly, intraoperative cystourethroscopy performed by us revealed that the urethra had been obstructed by an FB. The FB was gently pushed into the bladder and retrieved. The postoperative course was uneventful. The present case represents a rare occurrence of polyembolokoilamania or insertion of a FB into any bodily orifice for sexual gratification.

Psychiatric evaluation including mood and cognitive assessment was normal. His systemic and local examination was unremarkable.

INVESTIGATIONS

On investigations his routine blood/urine tests were normal. Uroflowmetry revealed decreased peak flow rates (8 mL/s), decreased average flow rate (5 mL/s) with raised postvoid residual urine of 220 mL. Imaging with retrograde urethrogram (RGU) and micturating cystourethrogram (MCU) revealed the presence of stricture in the region of the bulbar urethra with false tracts (figure 1). Based on clinical history, radiological imaging and cystoscopy was done previously, a provisional diagnosis of urethral stricture was made and the patient was scheduled for urethroplasty.

BACKGROUND

Many cases of a foreign body (FB) in urethra have been reported previously.¹ These include needles, pins, pen tip, plastic cup, olive seeds and so on. These are usually associated with old age, poor mental condition, intoxication or for sexual stimulation.² A proper history is vital in these cases as the history of FB insertion is often not revealed by the patient. In cases of suspected urethral stricture, a preoperative assessment with radiological imaging and cystourethroscopy must be mandatorily performed. The investigations should be interpreted with caution preferably by a specialist (urologist) before the patient is taken for definitive treatment. Herein we report a case of a 55-year-old male patient who was misdiagnosed as a case of urethral stricture based on an initial evaluation done at a primary healthcare centre and eventually found to have an FB in the urethra.

CASE PRESENTATION

A 55-year-old male patient was referred to our urology department in October 2017 from a primary healthcare centre with complaints of difficulty in voiding and thin urinary stream for the last 2 months. The patient initially presented with urethral bleeding and acute urinary retention. The discharge card mentioned that the patient had a constriction in the region of the bulbar urethra at the time of initial catheterisation necessitating a suprapubic catheter and tertiary referral. The patient denied any history of local trauma, sexually transmitted diseases, drug abuse or FB insertion.

DIFFERENTIAL DIAGNOSIS

1. Urethral stricture.
2. Urethral trauma.
3. Urethral FB.

TREATMENT

As a routine practice in our institute, we usually perform an intraoperative cystoscopy for all urethral stricture patients. The intraoperative cystoscopy examination, however, revealed a plastic FB (suggestive of the pen tip) in the region of the bulbar urethra with the presence of false tracts (figure 2). The FB was pushed into the bladder and was retrieved perurethrally through the cystoscopic sheath (figure 3). A 16 Fr perurethral catheter was placed, and the supra-pubic catheter was taken out after 3 days.

OUTCOME AND FOLLOW-UP

The perurethral catheter was removed after 2 weeks. At 1-month follow-up, there are no voiding complaints, and the patient is passing urine with a good flow (peak flow rate >15 mL/s). However, the patient, later on, admitted that he introduced the FB through his urethra for sexual gratification. The patient has yet to resume sexual intercourse.

DISCUSSION

FB in the urethra is a less commonly reported condition.¹ Patients usually present with complaints of dysuria, difficult voiding, retention and pain.^{2,3} These cases are usually diagnosed with a

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Figure 1 Micturating cystourethrogram/retrograde urethrogram image depicting stricture in the bulbar urethra with the presence of false tracts.

proper history and radiological investigations (RGU/MCU), but cystourethroscopy must be done in all cases to better diagnose radiolucent foreign bodies and urethral injury. Such patients tend to conceal their history due to social stigma. These foreign bodies can be removed transurethrally in most cases.^{1–3} Chan *et al*⁴ reported a similar case in which urethral avulsion was caused by self-insertion of a plastic tube perurethra. The patient admitted that the tube was inserted for sexual gratification. This patient was managed by emergency urethral realignment. The present case is one of self-insertion of a urethral FB for sexual gratification—polyembolokoilamania.^{5–7} Singh *et al*⁷ described a case of a 36-year-old man with multiple FBs in the urethra. The removal of FB was done in stages via cystoscopy. The patient should be thoroughly evaluated to look for the cause of polyembolokoilamania as it may be secondary to drug abuse, psychiatric illness like cognitive and mood disorders or sexual gratification.⁶ In rural areas of developing countries like India, the disease dynamics are complicated (due to poverty, availability of resources, lack of specialists and so on). Therefore, most of the patients living in rural areas first visit primary healthcare

Figure 2 Cystoscopy image depicting a foreign body in the region of the bulbar urethra.

Figure 3 Image depicting retrieved foreign body (pen tip).

centres and are subsequently referred to specialists if needed. All preoperative investigations in case of urethral stricture including MCU/RGU must be interpreted with caution, and an intraoperative cystourethroscopy must be mandatorily performed. Misdiagnosis of urethral foreign bodies can be catastrophic as it leads to inadequate management and prolonged treatment duration.

Learning points

- ▶ Polyembolokoilamania is an unusual insertion of objects in natural orifices for sexual gratification.
- ▶ A proper history is vital in the evaluation of polyembolokoilamania cases as patients tend to conceal the exact history due to social stigma.
- ▶ Intraoperative cystourethroscopy should be done in all cases of urethral stricture as micturating cystourethrogram/retrograde urethrogram is not completely reliable.
- ▶ Misdiagnosis of urethral foreign bodies as strictures can lead to inappropriate management.

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