

Case Report

An Electric Cable as a very Long Foreign Body in Urethra and Bladder

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Abstract

Foreign bodies in genital tract are often jokes among doctors. Foreign bodies are often introduced in urethra for auto-erotism. Although most foreign bodies can be removed easily but some cases require endoscopic or open surgical treatment. The main goal should be extraction of foreign body with minimal techniques to reduce penile trauma.

In the presented case, the urethro-vesical foreign body, an electric cable neither removed via urethra nor endoscopically, due to a knot in the bladder. Finally cable had to removed by open surgery (suprapubic cystostomy).

Introduction

Foreign bodies are inserted into the urinary tract because of sexual curiosity, pathological masturbation, mental illness or intoxication. Foreign bodies of the bladder may occur by self insertion or migration from neighbouring organs.¹ Most self-inflicted foreign bodies of the urethra and bladder can be removed endoscopically. The primary goal is extraction of the foreign body and preservation of urinary tract function (urinary voiding and erectile function) using invasive techniques.^{2,3} However in some cases open surgery becomes necessary. We present a rare case where the electric cable wire was inserted into the urethra. Due to a knot in the bladder, extraction via urethra was not possible so it was removed by open surgery (suprapubic cystostomy).

Case Report

A 25-year old man presented after inserting a long electric cable wire inside his penile urethra and unable to retrieve it outside. On direct questioning, he admitted of doing for sexual pleasure. There was no history of psychiatric disorder or other diseases and no previous history of surgery on urinary tract.

On clinical examination electric cable wire was hanging out from the tip of penis and small amount of fresh blood was present at tip of urethra (Fig. 1). On rectal examination, the cable wire palpable.

X-ray pelvis was done; it revealed long cable wire entering from tip of penile urethra with coiling inside the bladder (Fig.2).

An attempt is made to remove wire by giving traction on outside cable but it was not possible due to the knot inside the bladder. At this point, no further traction given and patient was prepared for surgery. Open suprapubic cystostomy done and electric cable wire extracted completely (Fig. 3). Suprapubic and perurethral catheter kept for healing process. Postoperative period was uneventful. Catheter was removed after couple of days and patient was discharged.

Discussion

Urinary bladder is the commonest site of foreign bodies in the urinary tract and if

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Fig. 1 : An electric cable wire is inserted in the penile urethra.



Fig. 2 : X-ray of the pelvis shows the cable in the urethra with coil and knot in the bladder.

neglected can lead to complication. Various case report describe unusual and seemingly dangerous object in the urethra like nuts, bolts, pens, pencil, toothbrush, wire, shred of glass and animal parts.⁴ One series reported that nearly 100% of the cases in the male and 85% of those in female, object were self inserted for erotic or sexual purpose.² Most patients are ashamed and do not come until they experience severe voiding problems.

Depending upon the size of the objects and the location management differs, but in some rare cases open surgery becomes necessary.⁵ In this case due to the knot of electric cable

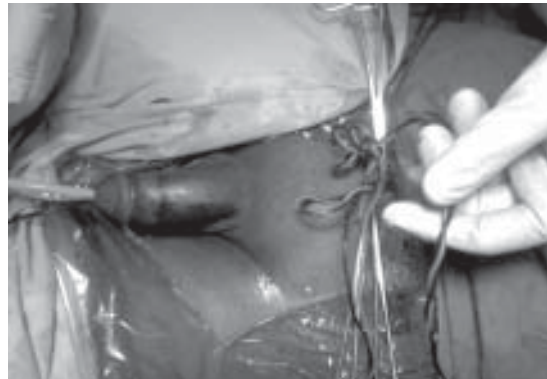


Fig. 3 : Suprapubic cystostomy with extraction cable wire completely.

in the bladder, pulling by holding distal end was not possible for removal of cable. Due to the fact that diameter of the cable was 5-8 mm; introduction of any endoscopic instrument was considered impossible at this point, no further mobilization was possible and the cable had removed by open surgery. The primary goal of the treatment should be removal of the foreign body with little damage to urinary tract as possible.

The long term complications of urethra-vesical foreign bodies include stricture diverticulum and erectile dysfunction. The rationale for the behaviour should be investigated to prevent recurrence.⁶

In conclusion, depending upon the location, size and form of the foreign body least invasive way to remove the foreign body should be chosen. Although foreign bodies currently removed endoscopically, in some cases open surgery cannot avoided.

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FINDING THE COURAGE TO RECONSIDER MEDICAL THERAPY FOR STABLE ANGINA

This advance has markedly altered clinicians' thresholds for considering PCI. Now, the presence of any angina can precipitate coronary angiography with PCI of amenable lesions. Even symptoms are no longer a prerequisite since aggressive strategies for cardiac screening may reveal lesions that can be treated with PCI. Consequently, the therapeutic paradigm has reversed, with medical therapy generally reserved for those who have exhausted revascularization options.

The COURAGE trial compared an initial strategy of PCI plus optimal medical therapy with optimal medical therapy alone for patients with stable angina and showed that patients in the two groups had similar rates of death or myocardial infarction over the course of 4.6 years of follow-up.

The main benefits of revascularization relate to improved quality of life and relief of angina.

However, although the benefits were significant, the comparative differences were small, leaving open the question of whether a PCI-first strategy is justified.

A remarkable finding from the COURAGE study was the rapidity of improvement in health status in both treatment groups. This should serve as encouraging news to patients with coronary disease.

At the same time, the rapid improvement with optimal medical therapy alone suggests that antianginal medications are underused in practice. However, this benefit persisted for only 6 to 24 months and does not account for other PCI-related "costs".

The periprocedural rate of myocardial infarction in the COURAGE trial was 2.8%. Consequently, for every 1000 patients treated with a PCI-first strategy, approximately 2 would die. It is difficult to assert that a PCI-first strategy should clearly be adopted routinely in patients with stable angina.

Thus, a very reasonable "take-home" message from the COURAGE trial is to pursue optimal medical therapy initially and if this is ineffective, turn to PCI.

PCI-first strategy provided the largest incremental benefit for those with a score on the Seattle Angina Questionnaire of less than 50 (corresponding to having angina several times a week).

Finally, these data show that 40% of patients in practice were not taking a beta-blocker or statin, emphasizing that there is a long way to go to realize the potential gains of optimal medical therapy before undertaking PCI.

Optimal medical therapy as first-line therapy, with PCI reserved for patients who do not have a response or who have severe baseline symptoms.

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