

## Severe Dysuria and Miction Pain in a Young Man

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### BRIEF HISTORY

A 36-year-old man had severe dysuria and miction pain that had developed for 5 days. He was treated in the out patient department for urinary tract infection but the symptoms exacerbated. Because of the severe difficulty in urination, a Foley catheter was inserted for urine drainage.

### CLINICAL INVESTIGATIONS

He was physically normal. Urinalysis revealed pyuria (White blood cell count numerous per high power field) and he was febrile (39.5°C). Digital rectal examination revealed a boggy and tendered prostate. No pus discharge was expressed from the urethral meatus during prostatic palpation. Renal sonography showed normal renal tracing. Results of blood chemistry tests were within reference ranges.

### URODYNAMIC STUDY

A video urodynamic study was performed and revealed a small bladder capacity during the filling phase. Uninhibited detrusor contraction occurred at the volume of 182 mL. The voiding detrusor pressure (Pdet) was 189 cm of water but the patient only voided few drops of urine (Fig. 1) (1).

### CLINICAL COURSE AND FOLLOW-UP

Under the diagnosis of acute prostatic abscess, the patient underwent a transurethral incision of the prostate (TUI-P). Two longitudinal incisions were made along the enlarged prostatic lobes. Much pus was drained from the prostatic gland. A Foley catheter was implanted and he received by broad-spectrum antibiotics for 5 days until the fever had subsided. After removal of the Foley catheter, he was able to void smoothly except for urge incontinence and post-micturitional dribble. Repeat video urodynamic study was performed 10 days after removal of the Foley

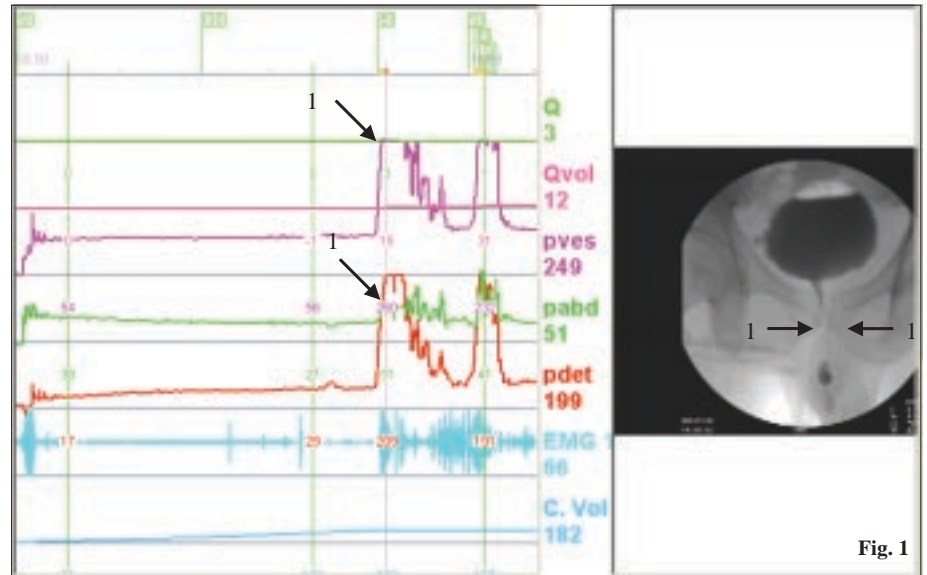


Fig. 1

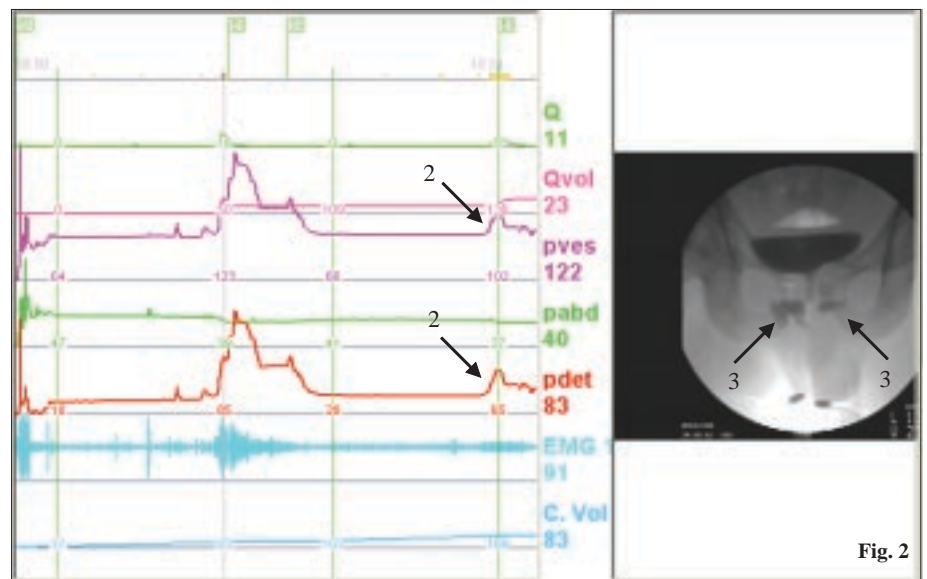


Fig. 2

catheter. The postoperative video urodynamic study revealed detrusor overactivity, small cystometric capacity, and reduced Pdet during voiding (2). Influx of contrast media was noted during voiding and the contrast media remained in the prostatic gland after voiding (Fig. 2) (3). High post-micturition contraction pressure was noted during the first pressure flow study, but it returned to normal Pdet on the second test.

### COMMENT

This is a typical case of acute prostatic abscess and bladder outlet obstruction resulting in acute urinary retention. After TUI-P the prostatic urethra was open but the abscess in the prostate formed cavities that caused postmicturitional dribble.