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Self-Inflicted Male Urethral Foreign Body Insertion Complicated with Overflow Incontinence and Scrotal Abscess

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INTRODUCTION

Self-inflicted male urethral foreign body insertion is uncommon condition though there are numerous cases have been reported [1-5]. Objects have included fishhooks, metal rods, wires, rocks, pellets, an AAA battery, tongue cleaner and cutton swabs [1-4]. Moreover, most cases often present with, dysuria, pyuria, frequency, haematuria, urinary retention, penile pain and/or swelling [2]. Urinary overflow incontinence was an unusual presentation of young adults. However, we presented a 27 years old young male who visited our hospital with an enlarged scrotum and incontinence for 4 days. After careful history taking and complete radiological evaluations, he admitted the etiology of self-inflicted urethral foreign body insertion.

BRIEF HISTORY

A 27 year-old young male adult came to our clinic with complaints of micturition pain, purulent discharge from urethra orifice and urinary incontinence for 4 days. On physical examinations, it was revealed a left swollen scrotum with severe tendeness and distended lower abdomen. Sonography of urinary bladder demonstrated urinary retention resulting in overflow incontinence and without soft tissue mass or foreign body in urinary bladder. Therefore, urethral Foley catheter was indwelled uneventfully and drained out about 1000 mL urine from bladder. This patient denied the history of trauma or abnormal sexual exposure at that time, through he got the history of amphetamine usage and depression. The urinalysis showed 50-70 white blood cells per high power field and 15-20 red blood cells per high power field. Leukocytosis with left shift was also noted with white blood cells 17200/μL. C reactive protein (CRP) was abnormal elevation upto 150.4 g/L. Owing to obvious infectious signs and symptoms, empiric antibiotics of cefazoline 1 gram every 6hours combined gentamycin 240 mg everyday were prescribed intravenously. Despite of the patient denying any infectious causes, we highly suspected uncommon etiology of urinary tract infection. Thus, abdominal and pelvic computerized tomography was performed in the second hospital day. Foreign body located near proximal penile urethra was idetified and diffuse inflammatory process with abscess formation also presented. At that time, the patient admitted self-inflcted urethral fishhook insertion after amphetamine abuse about one year ago but he stated that he did not remember it clearly because drug usage. Pelvic radiographic surveillance was examined to ascertain the exact shape, size and location of the foreign body. Surgery was planned through scrotal incision to remove the foreign body and drained abscess in the next day. After surgical intervention, the wound was opened with normal saline wet dressings were used for about one week untill the wound was clean. Then we repaired and re-anastomosed the scrotal wound after debridement and then removed urethral Foley catheter 3 days after surgery. This patient could void well with a maximal flow rate of 28 mL/s during follow-up period. We ever suggested psychiatric counseling to this patient but he did not agree our recommendation.

DISCUSSION

The most common motive for self-inflicted male urethra foreign bodies has been postulated as autoerotic stimulation, psychiatric illness or substance intoxication [1-4]. Many patients would be ashamed to admit they had inserted or applied any object and would give some irrelevant history [1,4]. Therefore, patients might be presented when a complication had occurred from the foreign body such as difficulty

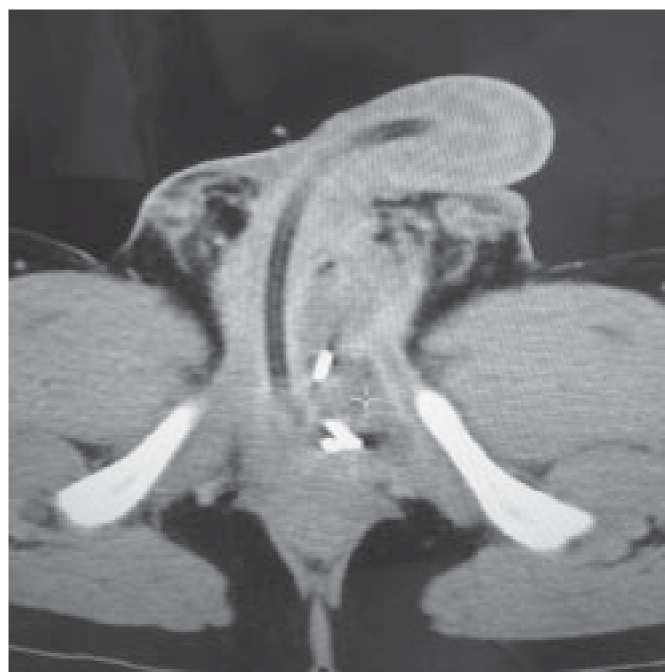

Fig. 1. Computerized tomography shows a metal foreign body in the parapenile proximal urethra and demonstrated the inflammatory process over scrotal regions with abscess formation.

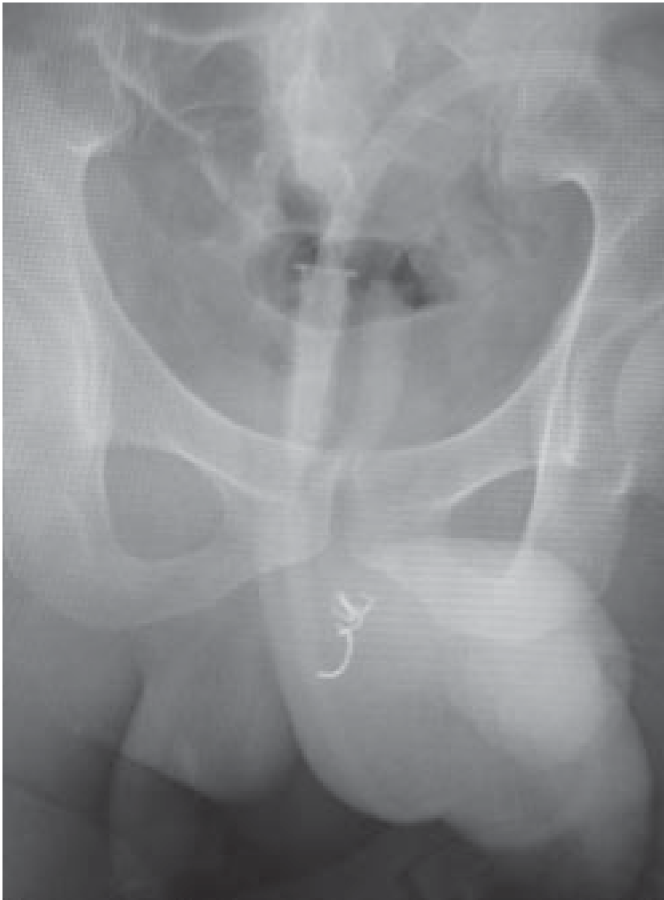

Fig. 2. Pelvic radiography shows a multi-hooked metal fishhook near the midline of scrotum.

Fig. 3. The foreign body was removed by open surgery.

voiding, hematuria, pain or swelling, extravasation, or abscess formation [4]. Our case was complicated with overflow incontinence and scrotal abscess. The patient tried to hide the history of self-insertion, possibly because of embarrassment, fear, or amphetamine intoxication, which probably delayed the diagnosis. Pelvic radiography and computerized tomography of the abdomen and pelvis can be useful in defining the position and orientation of a foreign body, and its relationship to and effects on the surrounding viscera [5]. We recommend radiologic evaluation for unusual incontinence or infectious in young adults. The method of removing a urethral foreign body depends on the size and mobility of the object in to the genitourinary tract. Endoscopic and minimal invasive techniques are suggested for removal when possible. However, surgical retrieval of a foreign body may be required, particularly when there is a severe associated inflammatory reaction [3]. Owing to the foreign body migration to the proximal urethra with obvious abscess formation, open surgery was done for this case. After foreign body removed, this patient was recovery with normal voiding function. But delayed complications can include urethral stricture, thus a close follow-up is indicated [1-2]. In addition, psychiatric evaluation should be done to prevent further attempts at insertion of other foreign bodies in the urinary tract [2].

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