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An Unusual Intravesical Foreign Body

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ABSTRACT

Foreign bodies of the urinary bladder may occur by self-insertion or migration from the neighbouring organs. An unusual foreign body in the urinary bladder in a clinical setting presents a diagnostic dilemma with a vague history. The patient usually presents with dysuria, intermittent urinary tract infection, or suprapubic pain. Here we report a case of an intravesical foreign body that was removed by cystoscopy.

INTRODUCTION

the urinary bladder is considered the main site of foreign bodies in the genitourinary tract. Many foreign bodies have been reported in literature, encompassing a bewildering array of objects available in the environment. Foreign bodies may enter the bladder by the migration of material used for masturbation iatrogenic, or the migration from surrounding structures like the vagina, cervix, uterus, or rectum [1]. Foreign bodies in bladder cause recurrent urinary tract infection, hematuria, urolithiasis, and pelvic pain [2]. Here we report an interesting case of self-introduction of the foreign body in the bladder.

CASE REPORT

A 21-year-old, unmarried, female teacher presented with a 6-year duration of dysuria.

No history of hematuria/pyuria was present. There was no history of pain in the abdomen or a fever. Her menstrual history was normal. Abdominal sonography showed a mass lesion arising from the right lateral wall of the urinary bladder. The X-ray KUB showed a radio-opaque pen tip seen on the right side of the pelvis (superimposed on the bone) (Figure 1). Cystoscopy showed a ballpoint pen lying horizontally in the urinary bladder. The tip of the pen was buried in the right lateral wall of the bladder around which granulation tissue

KEYWORDS: Urinary bladder; Foreign body

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Figure 1. X-ray KUB showing radio-opaque pen tip seen on the right side of the pelvis (superimposed on the bone).
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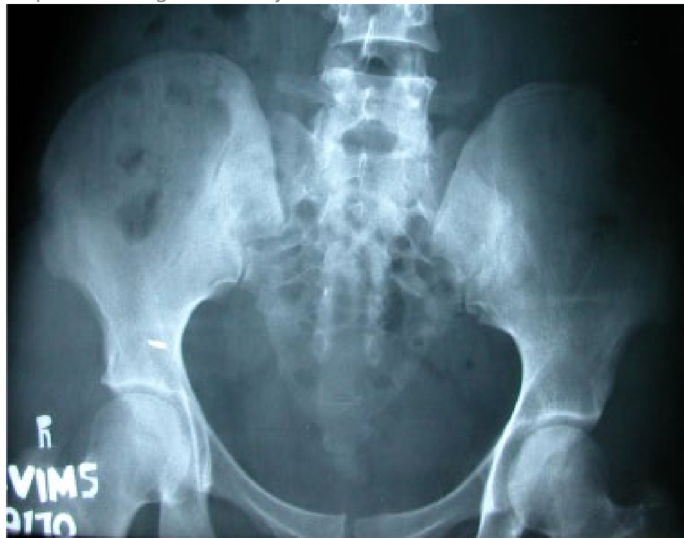

Figure 2. A pen removed by a cystoscope.
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was seen while the other end hitched onto the left lateral wall. A transurethral extraction of the pen was done and granulation tissue was sent for a histopathology (Figure 2). Histopathology of the granulation tissue showed no malignant changes. On retrospective questioning, the patient denied any self-introduction of a foreign body. The patient does not have any previous psychiatric history and she was referred to the psychiatrist postoperatively.

DISCUSSION

Foreign bodies in the genitourinary tract occur with such a frequency that every urologist and practitioner may expect to treat it rationally. A wide range of foreign bodies in the bladder have been reported in the literature [3], such as a retained urethral catheter tip, the tip of a ureteric catheter, or broken stents [4]. There are reports of transvesical migration or self-inserted foreign bodies, such as surgical sutures [5], metallic hip prosthesis [6], electric wires, pebbles, pencils, thermometers [7], and intrauterine contraceptive devices (IUCD) [8]. The presence of a foreign body in the urinary bladder acts as a nidus for crystal aggregation, proliferation, urinary tract infection (UTI), and stone formation [9].

Difficulty in the diagnosis lies in patients who choose to ignore the insertion of foreign bodies due to embarrassment. Patients with intravesical foreign bodies present either with recurrent UTIs or symptoms suggestive of a bladder calculus, such as dysuria, interruption of the urinary stream, hematuria, and suprapubic pain. Management is aimed at providing complete extraction that should be tailored according to the nature of the foreign body with minimal trauma to the bladder and urethra [10]. Most foreign bodies can be removed transurethrally with cystoscopic grasping forceps, but modifications of conventional instruments have been described to tackle difficult foreign bodies [11]. Open removal via suprapubic cystotomy is sometimes required.

CONCLUSION

The urinary bladder seems to be an accessible site for the introduction of a foreign body. Based on the evidence, every conceivable object has been inserted into the bladder. This has resulted in challenges regarding diagnosis and management for urologists.

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