Spontaneous Urinary Bladder Rupture Due to a Hypnotics Overdose

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Abstract

We reported on a hypnotic overdose young female who was taken to the emergency department because of abdominal pain, acute kidney injury, and an unexplained massive ascites. The final diagnosis was spontaneous urinary bladder rupture due to hypnotic-induced semi-coma. Hypnotics overdose greatly influenced the patient’s ability to urinate and contributed to prolonged urinary retention, which resulted in the rupture of urinary bladder. However, the history and physical examinations of these intoxicated patients are usually questionable. As a result, we proposed a triad of clinical manifestations – abdominal pain, acute kidney injury and a massive ascites. The presence of these clinical findings together should prompt physicians to consider spontaneous urinary bladder rupture.

Keywords: Urinary bladder rupture; Urinary retention; Acute kidney injury; Ascites; Abdominal pain; Hypnotics

Introduction

Spontaneous urinary bladder rupture is rare and it is difficult for physicians to diagnose the uncommon disease in intoxicated patients. We described a case of hypnotics overdose induced spontaneous urinary bladder rupture and demonstrate the useful clues for the diagnosis of this disease.

Case Report

A 28-year-old female was taken to our emergency department because of hypogastic pain that had persisted since that morning. The patient’s mother said that she was healthy previously and denied any medical or surgical diseases. Six days earlier, she had an attempt to commit suicide by ingesting a large amount of hypnotics and was admitted to another hospital in a hypnotics-induced coma. Her family could not afford the medical cost after 3 days of admission and she was taken home against medical advice. At that time, she was still drowsy and, bedridden and relied on the care of her mother. On the day of the patient’s visit to our emergency department, she complained of abrupt onset hypogastric pain that was not associated with nausea, diarrhea or fever.

Physical examination revealed an acute ill-looking and drowsy female with a pulse of 98 beats per minute, blood pressure of 154/101 mmHg, and temperature of 35.6°C. Her abdomen was distended and diffusely tender for palpitation. Her initial blood tests showed obvious leukocytosis and acute kidney injury with a white blood cell count of 24100/μl, a serum creatinine level of 11.1 mg/dl and a blood urea nitrogen level of 61 mg/dl. Other laboratory studies demonstrated a glucose level of 159 mg/dl, a sodium level of 134.4 mmol/l, a potassium level of 61 mg/dl. The urine collected by single catheterization revealed only a massive ascites (arrow). The urine collected by single catheterization revealed only a massive ascites (arrow).

Figure 1: Abdominal computed tomography scan without contrast enhancement revealed only a massive ascites (arrow).
or inflammation of bladder, are known to predispose patient's urinary bladder to rupture [1,2]. It is relatively easy for physicians to diagnose urinary bladder rupture in patients with pre-existing urinary bladder diseases. Prolonged urinary retention often occurred in debilitated, comatose or intoxicated patients. The history and physical examinations of these patients are usually incomplete and questionable, and as a result, physicians do not always consider the diagnosis of urinary bladder rupture [1,3]. For the case presented herein, the hypnotics overdose greatly influenced the patient's ability to urinate and contributed to urinary bladder distension, which ultimately resulted in the rupture of the urinary bladder.

Additionally, drug clearance is markedly affected in patients with kidney injury [4]. The peritoneum may reabsorb active metabolites of hypnotics from urinary ascites [5], and this reabsorption may have led to the prolonged depressed consciousness of the patient.

Most patients with spontaneous urinary bladder rupture present to the emergency department complaining of abdominal pain, suprapubic tenderness, difficulty in voiding, dysuria, and oliguria [1-3]. Their laboratory tests often reveal acute kidney injury, hematuria and leukocytosis, which deviate physicians to the inaccurate diagnosis of urosepsis [6,7]. If the physicians chose abdominal computed tomography to evaluate the patient’s abdominal pain, the utilization of intravenous contrast often be precluded owing to the presence of acute kidney injury [8]. In most circumstances, these non-contrast images are unable to demonstrate the defect in urinary bladder wall and show an unexplained, large amount ascites only. Accordingly, we proposed a triad of clinical manifestations for spontaneous urinary bladder rupture: abdominal pain, acute kidney injury and a massive ascites. The presence of these clinical findings together might prompt physicians to consider spontaneous urinary bladder rupture, especially for these patients who have experienced a period of a depressed consciousness state.

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