Case Report

Intravesical foreign body in a 12-year-old boy

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ABSTRACT

Self-insertion of foreign body in lower urinary tract is rare in children. It is commonly seen in adults. The reason for self-insertion may be accidental, due to psychiatric illness, curiosity, sexual stimulation or therapeutic in cases of stricture. Most of the cases reported are in adults. Here we present a 12-year-old child presenting with self-insertion of metallic hair pin into the lower urinary tract with symptoms of dysuria and retention of urine. X-ray and ultrasonography were diagnostic modalities which aided in the diagnosis. The child underwent successful cystoscopic removal of foreign body after thorough investigation. Post removal child underwent psychiatric evaluation. He was not suffering from any psychiatric condition. He admitted having inserted the hair pin out of curiosity. Child was passing urine in good stream at time of discharge. At six months follow up child remains asymptomatic.

Keywords: Cystoscopy, Foreign body, Self-insertion

INTRODUCTION

Foreign body in the bladder may occur due to self-insertion or migration from surrounding organs. Self-introduction of foreign body into the lower urinary tract in children is rarely reported.1

Reasons for self-insertion of foreign body include psychiatric, autoerotic, therapeutic purpose or no definitive reason.2 Most of the cases seen are in older age groups. The male urethra is about 16 -20 centimetres in length and lumen diameter is about 8-9 millimetres. Hence insertion of foreign body through the urethra into the bladder is difficult to understand. According to Jung et al foreign body in the urinary bladder is a rare occurrence.3 Martinez-Valls et al described this condition as exceptional and not a common emergency.4 The presentation of these cases is usually delayed due to the fear of embarrassment. The diagnosis and management of lower urinary tract foreign body requires expertise. Usually radio opaque foreign bodies are detected by X-ray while other foreign bodies require ultrasonography for detection. Treatment includes extraction of foreign body without causing injury to the urinary tract. Most of the cases are treated using minimal invasive techniques following advances in endoscopy. Very few cases require open surgery. Here we present a 12-year-old boy with a metallic hair pin in the bladder.

CASE REPORT

12-year-old boy presented with history of dysuria and difficulty to pass urine to a peripheral hospital. He underwent a single shot catheterization to relieve his symptoms. Child was asymptomatic for few hours, but in view of recurrent lower abdominal discomfort he consulted for the second time. An abdominal X ray and an Ultrasound (Figure 1 and 2) was done which revealed radio opaque shadow in the region of the bladder. On re-enquiring the child, he admitted having inserted a hair pin...

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into the urethra out of curiosity. The child was referred to our centre for removal of foreign body.

![Figure 1: X-ray showing foreign body in bladder.](image)

![Figure 3: Removal of foreign body.](image)

DISCUSSION

Foreign body in the bladder and urethra are due to self-insertion, migration from surrounding sites secondary to iatrogenic or traumatic causes.

Self-insertion into urinary tract may be due to accidental, psychiatric illness, curiosity, and sexual stimulation or therapeutic in cases of stricture. In children self-insertion of foreign body is rare. It usually occurs during puberty or start of puberty.

Various type of foreign body has been reported. These include plastic caps, paper clips, hooked wire, metal objects, shells, glass rods, light bulbs. In our case the child had inserted a hair pin into the urethra. Due to catheterization the foreign body was pushed into the bladder.

Children around puberty are usually ashamed to admit that they have inserted an object into the urethra. In the present case the child had initial apprehension to admit that he had inserted a hair pin into the urethra, but in view of persisting problem he had to admit.

The commonest symptom is dysuria. Other symptoms include hematuria, swelling of genitalia, extravasations of urine, abscess formation, urinary retention. The initial investigation is a plain X-ray to know the site, size, position, composition of foreign body. Most of the foreign bodies are picked up by an X ray. In few cases Ultrasound and CT scan might be required. Both Ultrasound and an X ray was done in the present case before child presented to us.

Objectives of treatment include diagnosing complications, removal of foreign body and avoidance of complication to urethra.

Foreign body can be removed via cystoscopy, which is the least invasive method. The other options include open exploration, percutaneous suprapubic retrieval under
direct visualization via cystoscope. Open exploration is the most invasive but highly successful method. In the present case foreign body was successfully removed via cystoscope.

Complication of self-insertion of foreign body includes bladder perforation, urethral injury, urethrocutaneous fistula, urinary tract infection, erectile dysfunction, urethral diverticulum. Long term complication of untreated foreign body includes recurrent urinary tract infections, squamous cell carcinoma, calcification of foreign body, migration of foreign body, stone formation, and urethral stenosis.

Psychiatric evaluation of these children is a must in case of self-insertion. In puberty most of the cases of self-insertion is because of curiosity as was with our case.

CONCLUSION

Though lower urinary foreign bodies are rare in children, proper evaluation is required. Treatment includes retrieval of foreign body without causing complication. All patients require psychiatric evaluation before discharge.

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