Foreign bodies in the bladder are among the strangest differential diagnoses in the lower urinary tract symptoms (LUTS) and may be missed in initial medical evaluations. We present a 63-year-old man who was visited in the emergency department because of obstructive and irritative lower urinary tract symptoms. Two months earlier, he had a pelvic fracture due to motor vehicle accident and underwent an open reduction and internal fixation of the pubic rami and right acetabulum by an anterior ilioinguinal approach. After initial evaluation, an abdominopelvic X-ray revealed a 3 cm screw in the suprapubic area. He underwent urethrocystoscopy and a 3 cm screw was extracted by forceps.

A 63-year-old man was visited in the emergency department because of obstructive and irritative lower urinary tract symptoms. Two months earlier, he had a pelvic fracture due to motor vehicle accident and underwent an open reduction and internal fixation of the pubic rami and right acetabulum by an anterior ilioinguinal approach. His symptoms began 1 week after the surgery and he constantly suffered from dysuria, frequency, and urinary hesitancy ever since. His past medical history was otherwise unremarkable. On physical examination, he had no fever and no abnormality was seen on the head, neck, and chest examination. Abdominal examination revealed a 5 mm cutaneous fistula in the previous surgical scar in the right hip and an amount of leakage leading to inflammation and erythema in the skin surrounding the area of the fistula.

Urine analysis showed pyuria and microscopic hematuria and blood count and biochemistry profiles were within normal limits. After initial evaluations, an abdominopelvic X-ray revealed a 3 cm screw in the suprapubic area (Fig. 1). A spiral abdominopelvic CT scan was requested which showed the screw was in the bladder. Furthermore, extravasation of the contrast media in the anterior aspect of the bladder was seen. According to imaging studies, it seemed that the screw was fixed to adjacent pelvic organs.

He underwent urethrocystoscopy and a 3 cm screw was seen in the posterior aspect of the bladder which moved freely inside the bladder (Fig. 2). The screw was extracted by forceps (Fig. 3). The bladder was drained by a 22-Fr Foley catheter. Three weeks later, the urinary catheter was removed and cystography was performed that showed no bladder extravasation. Moreover, the cutaneous
Fistula was completely closed at this time. In 3 months follow-up, the patient voided normally and no leakage from fistula was seen. Repeated CT cystography revealed no pelvic or bladder abnormality.

Discussion

Bladder foreign bodies are challenging problems to urologists. The patients may complain of lower urinary tract symptoms. Initial management of the patients with intravesical foreign bodies should consists of providing pain relief and control of irritative voiding symptoms by prescribing analgesic and anticholinergic drugs, respectively. Antibiotics may be required for the control of urinary tract infection and prevention of sepsis in infected patients. Endoscopic removal of foreign bodies has been successful in most case reports. Frenkl, TL reported endoscopic treatment of mesh erosion in four patients that was successful in two of them. Holmium:YAG laser has also been successfully used to remove intravesical foreign bodies. If minimally invasive procedures fail to remove foreign bodies, suprapubic cystostomy or open surgery may be performed. In our case, after endoscopic removal of the foreign body, urinary leakage from the suture line became dry and the cutaneous fistula was closed after transient urinary catheterization without requiring other treatments.

Conclusion

Based on our experience, urologists should be aware of the probability of existing lower urinary tract foreign bodies in patients with unusual lower urinary tract symptoms, especially if there is a positive history of pelvic surgery.

Conflict of interest

No competing financial interests exist.

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