Searching for the G spot in the urinary bladder: autoerotism and potential complications

Marius Craciun*, Savvas Omorphos, Rahul Lunawat and Subramanian Kanaga-Sundaram

Urology Department, Pinderfields Hospital, Mid Yorkshire NHS Trust, Wakefield, UK

*Correspondence address. Urology Department, Pinderfields Hospital, Wakefield, West Yorkshire WF1 4DG, UK. Tel: +01924-541000; E-mail: mariusemil.craciun@yahoo.com

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INTRODUCTION

Over the past decade, reports in the literature of self-inserted intra-vesical and intra-urethral foreign bodies have increased [1–3]. The cause for most foreign bodies in the lower genitourinary tract is multifactorial. Typically, objects are self-inserted via the urethra as the result of erotic impulses, psychometric problems, sexual curiosity or sexual practice while intoxicated.

Diagnosis of these foreign bodies can be done by a combination of clinical history, physical examination and radiological studies of the patient. The removal of the foreign body is determined by its size, location, shape and mobility. In most cases, minimally invasive procedures such as endoscopic removal are recommended to prevent bladder and urethral injuries. However, in some cases, major open surgery is mandatory if the foreign bodies cannot be removed by endoscopic procedure or further injuries are expected as a result of the endoscopic procedures.

CASE REPORT

We present the case of a 41-year-old lady who self-referred to the Emergency Department for lower abdominal pain associated with dysuria. The patient had self-inserted 24 hr previously, without being constrained, a crochet needle into her urethra out of sexual curiosity. On examination, the patient was clinically stable and her abdomen was soft but mildly tender suprapubically, without evidence of guarding or peritonism.

An X-ray of her pelvis showed a 3-cm radiopaque foreign body (Fig 1). The patient underwent an examination under anaesthesia and a diagnostic rigid cystoscopy was performed which identified a 9-cm crochet needle in the bladder, with the sharp end lodged in the mucosa of the proximal urethra (Fig 2). There was evidence of debris in the bladder but no signs of bleeding or bladder wall injury or perforation. The foreign body was removed successfully with graspers and bladder washouts were undertaken to clear the debris from the bladder. The procedure and the recovery were uneventful. A psychiatric consultation was recommended, but the patient refused. She was discharged on the following day and she was prescribed oral antibiotics for 5 days. Unfortunately, the patient failed to attend the follow-up appointment.

DISCUSSION

Case reports on this subject have been published from the early days of modern medical publishing.

Typical circumstances that lead to self-insertion of foreign bodies are erotic impulses, mental illness or borderline personality disorder, sexual curiosity and play during intoxication. However, the most common motive associated with foreign bodies in the genitourinary tract is sexual or erotic in nature, such as masturbation and other forms of sexual
gratification or variations [2]. Patients thereafter usually feel embarrassed and tend to avoid seeking immediate medical help and may make several attempts to remove the objects, resulting in further migration and injury.

Regarding the psychoanalytical aspect, there are a few theories for self-insertion of devices for sexual gratification. Kenney’s theory states that the initiating event is an accidentally discovered pleasurable stimulation of the urethra, which is followed by repetition of this action using objects of unknown danger, driven by a particular psychological predisposition to sexual gratification [3, 4]. Other authors consider these acts as an indication of an impulsive behaviour which is self-punishing in nature and that may aggravate to suicide and recommend a psychiatric evaluation of all these patients [4, 5]. In our case, the patient was counselled to undergo a psychiatric consultation, but she refused.

Various complications can occur as a direct result of intra-vesical foreign bodies, if left untreated. Commonly early symptoms include suprapubic pain, cystitis, dysuria, frequency and/or haematuria. Others can be asymptomatic. More severe complications may arise in the long term, such as chronic or recurrent urinary tract infection, urinary retention, calcification, hydronephrosis, posterior urethral injury, obstructive uropathy, vesico-vaginal fistula, squamous cell carcinoma and sepsis and so early recognition and treatment is necessary.

The diagnosis can be done by thorough clinical history, physical examination and imagistic studies. Radiological evaluation is necessary for diagnostic purposes in order to determine the size, location and number of foreign bodies prior to planning therapeutic intervention [6]. Plain X-ray or ultrasonography usually provides sufficient information required to proceed with the intervention; computer tomography scan is rarely used [7].

Definitive management of foreign bodies aims to provide complete removal of the foreign body with minimal complications. This may be quite challenging requiring improvisation and high-level surgical skills. Because of the anatomy of the female urethra, foreign bodies in the bladder are usually removed endoscopically. Only sharp or large objects need open removal. Delayed complications such as urethral stricture may occur and so close follow-up is recommended if possible. Kochakarn et al. reported an incidence of urethral stricture of only 5%, but most of the patients fail to return for their follow-up visits, and thus the true incidence of urethral stricture may be higher [8] and so this potential complication should be discussed with the patient. It should be emphasized that it is the insertion of the foreign body, not its retrieval, which is the primary risk factor for stricture disease [9].

Foreign bodies into the urethra inserted for autoerotic stimulation is a rather rare urological emergency. Endoscopic manipulation is the preferred first-line treatment for intra-vesical foreign bodies and if unsuccessful, open procedures may be necessary. Radiological evaluation is necessary to determine the exact size, number and nature of foreign bodies. Psychiatric consultation should be done to prevent further attempts of insertion of other foreign bodies in the urinary tract.

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