

# Migrated Urethral Catheter In The Urinary Bladder Forming A Stone And Presenting As Recurrent Urinary Tract Infections

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## Abstract

A secondary vesical calculus develops in the presence of outflow obstruction, infection or in the presence of a foreign body. A 19-year-old Hindu male, manual laborer by occupation and resident of an urban slum, presented to the surgery OPD with one year old complaints of suprapubic pain, frequency of passing urine, low grade hematuria, fever and passage of foul smelling urine with pus for the past 6 months. History revealed retention of urine one year before. The patient went to seek the advice of a local practitioner, who inserted a hollow tube transurethrally. Urine culture revealed E.coli in significant levels sensitive to Cefotaxime and Norfloxacin. A plain X-ray KUB showed a mass suggestive of a single bladder calculus. On detailed examination of the stone, a secondary calculus appeared developed over a mass of coiled tube. The stone was removed via suprapubic cystostomy.

## INTRODUCTION

A secondary vesical calculus develops in the presence of outflow obstruction, infection or in the presence of a foreign body. Presenting features include suprapubic pain, dysuria, frequency of micturition and hematuria. Diagnosis is by a plain X-ray KUB or an ultrasonography, which shows a radiolucent shadow changing position with patient movement. Treatment is by endourological procedures or a suprapubic cystotomy if the stone is large (size greater than 3 cm).<sup>1</sup>

## CASE REPORT

A 19-year-old Hindu male, manual labor by occupation and resident of an urban slum, presented to the surgery OPD with complaints of

- Suprapubic pain for the past 1 year
- Frequency of passing urine for the past 1 year
- Hematuria for the past 1 year
- Fever, low grade, off and on for the past 1 year
- Passage of foul smelling urine with pus for the past 6 months

On taking a detailed history, it was recorded that the patient had an episode of severe suprapubic pain, dysuria and a sudden onset of retention of urine 1 year before. The patient went to seek the advice of a local practitioner, who inserted a hollow tube transurethrally by which urine was drained. The patient was also given oral medication. The patient did not pay heed to the hollow tube and did not have any other episode of retention. He did not note what happened to the tube after that. There is no history suggestive of tuberculosis or diabetes mellitus. Since then the patient had the above symptoms repeatedly and was treated by a local practitioner.

A general physical examination did not reveal any abnormality except pallor. On per abdomen examination there was suprapubic tenderness. Urine culture revealed E.coli in significant levels sensitive to Cefotaxime and Norfloxacin. Hemoglobin was 8.6gm% and TLC was 12500/cu mm. A plain X-ray KUB revealed a mass suggestive of a single bladder calculus. Blood sugar, blood urea and serum creatinine were normal. Preanesthetic investigations were done and the stone was removed via suprapubic cystostomy. Intravenous Cefotaxime was given to the patient for 5 days. Postoperatively, the patient was also given Norfloxacin for 5 days. The stitches were removed on day 8 and the patient was discharged. When the patient reported for follow-up 3 months later, he was asymptomatic

and urine culture was sterile.

On detailed examination, the stone appeared as a secondary calculus developing over a mass of coiled tube shown in figure 1.

**Figure 1**

Figure 1: Photograph of specimen removed from the bladder



**DISCUSSION**

Recurrent urinary tract infection is uncommon in males and usually occurs due to an abnormality of the urinary tract, stricture or foreign body<sup>1</sup>. In our case, a hollow tube was inserted which migrated into the bladder, with the patient unaware. A foreign body in the bladder has been documented as a cause of recurrent urinary tract infection<sup>2</sup>.

A detailed history and a high index of suspicion help to arrive at the diagnosis. Plain X-ray KUB and ultrasonography confirm diagnosis. Antibiotic therapy should be guided by culture and sensitivity.

**References**

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2. Rafique M. Case report: An unusual intravesical foreign body: Cause of urinary tract infections. Int Urol Nephrol. 2002; 34(2): 205-6

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