

Unusual self-inflicted foreign bodies in the urethra

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ABSTRACT

Self-inflicted urethral foreign body insertion in men is very rare and an important condition which urologists encounter in their clinical practice. Urologists should be familiar with the different techniques for the removal of these foreign bodies. Most cases are associated with psychiatric disorders. Hence, they should be referred for complete psychiatric evaluation. The emotional condition of the patient and the circumstances under which this act was committed should be investigated at the same time. Many cases of self-inflicted foreign body in the urethra have been reported in the literature such as fishhooks and bullets. However, metallic tongue cleaner in urethra has not yet been reported. Here, we are reporting the case of a 28-year-old male who presented with dysuria for 1 day following insertion of metallic tongue cleaner in the penile urethra, for sexual gratification which, he was unable to remove. The foreign bodies were found in the anterior urethra on X-ray and were successfully removed endoscopically without any complication. The patient was advised to take psychiatric consultation and counseling to prevent future episodes.

Key words: Foreign body, Self-inflicted, Urethra

Self-insertion of foreign bodies into the urethra for sexual gratification is an unusual but important condition which urologists encounter in their routine clinical practice [1]. Many cases of self-inflicted foreign bodies such as screw, metal rod, fishhook, bones, light bulb, vibrator, and bullet in the male urethra have been reported [2-6]. However, the insertion of metallic tongue cleaner in the urethra has not yet been reported. Most cases are associated with psychiatric disorders, senility, intoxication, or autoerotic stimulation. The patients often present with frequency, dysuria, hematuria, urinary retention, penile pain, and/or swelling. The prevalence of the condition is unknown and might be due to the embarrassment of patients. Hence, a high index of suspicion and targeted history taking is important to correctly diagnose the condition. Urologists should be familiar to manage this condition.

Here, we present the case of a 28-year-old male, who presented with broken pieces of metallic tongue cleaner (self-inserted, for sexual gratification) in the urethra which was removed endoscopically and followed up to look for and prevention of urethral stricture.

CASE REPORT

A 28-year-old male presented with a complaint of dysuria for the past 1 day. On careful interrogation, he said that he used to insert

metallic tongue cleaner in his urethra for sexual gratification for the past few months. However 1 day ago, he was unable to remove that tongue cleaner after insertion. Following this, he complains of dysuria.

On examination, the patient was anxious with a heart rate of 104 bpm and blood pressure of 128/76 mmHg. Local examination revealed a non-distended bladder, normal external urethral meatus, and two palpable long foreign bodies (one at the penile urethra and another at the bulbar urethra).

His blood reports were within normal limits and an X-ray of the pelvis and external genitalia showed two radio-opaque structures at the anterior urethra (Fig. 1).

Under spinal anesthesia and lithotomy position, a cystoscopic examination was done after proper lubrication which showed two broken pieces of metallic tongue cleaner (one at penile urethra about 3 cm proximal to external urethral meatus and other at bulbar urethra) (Fig. 2a). These foreign bodies were removed one by one (distal then proximal) cystoscopically using forceps with gentle external pressure by a surgical assistant (Fig. 2b). After removal, again cystoscope was introduced which showed few longitudinal mucosal injuries at the anterior urethra with bleeding from the injured site. A 16 Fr Foley catheter was introduced per urethra. Hemostasis was secured by external compression of the penis for 10 min. The patient was discharged the same day with a Foley catheter *in situ*.

After 10 days, a catheter was removed and uroflowmetry was done which showed a voided volume of 245 ml and a maximum

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Figure 1: Plain X-ray of pelvis showing two long radio-opaque foreign bodies in the male urethra

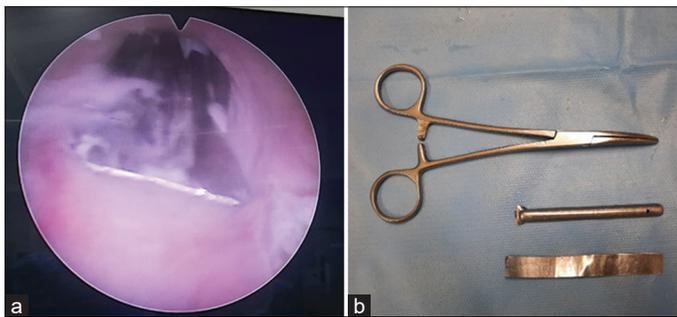


Figure 2: (a) Cystoscopic image showing metallic foreign body with sharp edges in the male urethra; (b) from above downward: Upper – mosquito forceps (to access the size of foreign bodies), middle – metallic foreign body at the proximal part of urethra, and lower – metallic foreign body at distal part of urethra

flow rate (Q_{max}) of 23 ml/s. The uroflowmetry curve was bell shaped. We asked him to look for any thinning of urinary stream, dysuria, etc., and followed up on an outpatient department basis. We advised him to take psychiatric consultation and counseling to prevent future episodes.

DISCUSSION

Self-insertion of foreign bodies into the urethra by male patients is an important condition as this may be complicated when the object migrates proximally into the proximal urethra or the bladder and is not retrievable. The patient attempts to remove the objects, causing further proximal migration of foreign body and urethral injury.

The patients with suspicion of foreign body in urethra should be evaluated with a proper history (to access to the type of foreign body, duration since insertion), inspection and palpation of the penis and scrotum, and imaging studies. A plain X-ray of the pelvis is sufficient in many cases to identify these foreign bodies. However, if the foreign body is radiolucent, then other modalities are required to confirm the presence and location. In one study, an X-ray was unable to identify the foreign body and the flexible

cystoscopy revealed soft tubing inside [5]. Computed tomography scan is indicated only in patients with features of peritonitis or when there is suspicion of foreign body migration to the adjacent organ [3].

Urethral catheterization and manipulation of the foreign bodies may cause further urethral injury and should be avoided until the exact type, number, size, shape, and location are determined. These patients should be treated with broad-spectrum antibiotics to prevent infectious complications. It was found that simple measures like milking of the urethra have a high success rate for removal of foreign body in the distal penile urethra [7].

With the advancement of endoscopic procedures, endoscopic retrieval of these foreign bodies should be tried first. Invasive procedures, such as open cystostomy and perineal urethrostomy, have been reported for retrieval of larger size, encrusted, or sharp objects after failed endoscopic procedures [8]. More complex procedures, such as laparotomy and urinary diversion, may be required in complicated cases. The surgical approach should be individualized [9]. Psychiatric consultation of all patients is needed [7].

CONCLUSION

Self-inflicted urethral foreign body insertion in men is very rare and an important condition which urologists encounter in their clinical practice. Urologists should be familiar with the different techniques for the removal of these foreign bodies. Most cases are associated with psychiatric disorders. Hence, they should be referred for complete psychiatric evaluation.

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