

Self-inflicted needle in the urethra retrieved endoscopically from the bladder

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The urethra that normally serves as an exit passage for urine also served on rare occasions as an entrance passage for a wide variety of foreign bodies. The most commonly administered objects are different types of pins and pencils.¹ More unusual objects included speaker wire, rocks, eye-wear rims, AAA battery, open safety pins, plastic caps, straws, a marble, a cotton-tipped swab and a metal screw.^{2,3} We reported a case of self-inflicted needle in the urethra that migrated to the prostatic urethra, and removed endoscopically from the bladder without causing significant complications.

A 38-year-old male presented to the Emergency Department with a weak urine stream and post-voiding spotting. These symptoms started after self introduction of a needle with a plastic knob at one end into the urethra. He introduced first the plastic knob for the purpose of scratching the urethral wall from an urethral itching sensation felt by the patient. Before introducing the needle, he bent its distal sharp tip to create a 30° angle that would assist him manipulate the knob inside the urethral lumen. He carried out this procedure on frequent occasions for a period of 3 weeks. On one occasion, the distal tip of the needle accidentally slipped completely into the urethra making it impossible for him to retrieve it back. This incident was facilitated by simultaneous use of a herbal gel that was ejected urethrally through the urethral meatus to allow adequate lubrication for scrubbing of the needle hub against the urethral walls. Although, the needle disappeared completely inside the urethra, voiding was mildly affected. He experienced a weak stream with post-voiding spotting in the underwear. Local physical examination revealed mild perineal tenderness in the midline. No palpable mass was felt, and no abnormalities were noted by rectal digital examination. A scout x-ray film of the pelvis showed a rod-like radio-opaque shadow at the level of the prostate that matched with the needle described by the patient. The knob at its proximal end was radiolucent and did not appear in the film (**Figure 1**). The patient was transferred to the operating theater for cysto-urethroscopy under general anesthesia. The urethra appeared healthy, and we saw the needle floating in the bladder lumen. The needle migrated spontaneously from the



Figure 1 - Scout pelvic x-ray film showing a rod-like radio-opaque shadow in the area of the prostatic urethra.

penile urethra to the prostatic urethra. It was pushed back to the bladder during the introduction of the cystoscope. Fortunately, the sharp tip of the needle did not penetrate the urethral or bladder wall, nor did it cause any significant injury to these structures. The sharp end of the needle was grasped endoscopically with a forceps, and was extracted out from the urethra without difficulty. No indwelling catheter was required postoperatively, and he was discharged on the following day with uneventful recovery.

Foreign bodies in the urethra or bladder are usually self-inflicted by men who are mentally disturbed, intoxicated or for autoerotic stimulation.² The patient involved in this case report was a man with sound mentality, and no sexual drive. He merely chose to use the needle as a means of alleviating the itching urethral sensation he experienced. It is not understood how such objects can migrate from the distal penile urethra back to the proximal urethra or even the bladder. In our case, the self-inflicted needle reached the prostatic urethra, and was endoscopically pushed back to the bladder before being retrieved. Although, significant complications can result from foreign bodies introduced in the urethra, our patient with the urethral needle had mild urinary symptoms. He reported to the Emergency Department only as he was very anxious to have this needle out. Neglected cases can cause complications as perforation and fistula formation.^{4,5} Most foreign bodies in the bladder can be endoscopically retrieved using grasping forceps and retrieval baskets.¹ This was achieved in our patient without complications, and he was discharged from the hospital 24 hours later.

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References

1. Ophoven A, DeKernion JB. Clinical management of foreign bodies of the genitourinary tract. *J Urol* 2000; 164: 274-287.
2. Rahman NU, Elliott SP, McAninch JW. Self-inflicted male urethral foreign body insertion: endoscopic management and complications. *BJU Int* 2004; 94: 1051-1053.
3. Gonzalgo ML, Chan DY. Endoscopic basket extraction of a urethral foreign body. *Urology* 2003; 62: 352xvii-352xviii.
4. Bird ET, Huckabay C, Waxman JA. Endoscopic evangelism: unique presentation and management of perforating urethral foreign bodies. *Urology* 2004; 64: 1229-1230.
5. Chu MK, Lee KF, AhChong AK. Urethral foreign body causing urethral fistula in a 13-year-old boy. A case report. *J Hong Kong Med Assoc* 1994; 46: 328-330.

Torsion of an epiploic appendix mimicking acute appendicitis

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Disorders of the epiploic appendages are rare, usually affecting the middle age group.^{1,2} They are rarely diagnosed preoperatively being commonly confused with diverticulitis of the sigmoid colon, and other causes of acute abdominal pain. Conservative treatment with antibiotics and pain relief is usually safe. We present a case of a young girl with acute epiploic appendagitis being diagnosed preoperatively as appendicitis, and we review the literature.

A 16-year-old girl presented to our Accident and Emergency Department with 2-day history of right iliac fossa pain, which she described as a continuous ache sometimes radiating to the back. She felt generally unwell, and her appetite was poor. There was no history of vomiting although, she was nauseated. Her bowels were regular and she denied any symptoms of urinary tract infection. Her history was not significant apart from the fact that she had irregular periods. On examination, she was comfortable at rest with a temperature of 36.7°C, a pulse of 94 beats/min, and a BP of 113/75. System examination revealed no abnormal findings, and examining her abdomen she was markedly tender in

the right iliac fossa with rebound tenderness and some guarding. The rest of the abdomen was soft with normal bowel sounds. Per rectum examination was normal. Laboratory investigations showed a normal Hb, a white blood cell count of 6.5 cells/mm, a normal differential count, and normal urea and electrolytes. The urine tested positive for blood (patient was menstruating), but was negative for leukocyte, proteins and nitrates. In view of the history and the signs on abdominal examination, she was diagnosed as having acute appendicitis, and was taken to the theater for an appendicectomy. At operation, there was some serosanguineous fluid in the right iliac fossa. The appendix looked normal, but there was a gangrenous appendix epiploica on the surface of the cecum. The patient underwent an appendicectomy with excision of the gangrenous necrotic fat on the cecum. Her postoperative course was uneventful, and she went home 24 hours after the operation. The histology revealed a congested hemorrhagic, and partly necrotic adipose tissue, consistent with the clinical diagnosis of strangulated appendix epiploica. The appendix showed no significant histological abnormality. Epiploic appendages are pedunculated, fatty structures around 2-5 cm in diameter scattered all over the colon, and covered with peritoneum. They are bigger in size and more prominent on the left side of the colon compared with the right side. Epiploic appendagitis affects the sigmoid colon more than the cecum and ascending colon.¹ Diseases of the epiploic appendages are difficult to diagnose clinically due to the lack of pathognomonic clinical features, but with the increasing use of CT scan for assessing cases of acute abdominal pain, their preoperative diagnosis is now more common. They affect the middle age group with a peak incidence at around the age of 40 years.¹ Necrosis of the epiploic appendages is commonly due to an ischemic event either secondary to torsion or spontaneous thrombosis,² but can also be due to a non vascular event. One can often confuse the condition with diverticulitis of the sigmoid colon, but it can mimic acute appendicitis when it affects the cecum. Patients usually present with a sudden onset of sharp localized pain either in the left or right iliac fossa with minimal gastrointestinal symptoms. The temperature and white blood cell count can be normal or slightly elevated. We can use both ultrasound and CT scan for reaching the diagnosis of epiploic appendagitis. The infarcted appendix has a characteristic sonographic appearance. It shows as a hyperechoic non compressible ovoid structure near the colonic wall. The use of color Doppler demonstrates the absence of blood flow in these lesions.³ In addition to confirming the diagnosis in doubtful cases, CT scan is also useful in the follow up of patients treated conservatively.⁴