SPONTANEOUS EXPULSION OF LARGE MIGRANT BLADDER CALCULUS CREATING LARGE URETHRAL FISTULA AND LARGE DISTAL PENILE ULCER

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ABSTRACT

Spontaneous expulsion of small bladder calculus per urethra or its impaction producing various symptoms ranging from dysuria to acute retention of urine is common presentation for urosurgeons, but bladder stone getting impacted in distal urethra and enlarging to a size > 5 cm is quite rare. A 65 years old chronic alcoholic patient presented 1yr back with features of prostatism and small bladder calculus on USG prostate was 35 cc, bladder calculus size 4mm. X-ray KUB also done. He was given medical management but patient being negligent and non compliant lost follow up, returned to our OPD after 1yr with large distal penile urethral fistula and distal penile ulcer following expulsion of solitary calculus measuring 5.5 cm x 3.5cm day before. Patient was passing urine through that fistula & there was no history of passage of urine per rectum. Per rectal examination revealed enlarged prostate with no nodularity. No h/o operation was present. Urine culture showed presence of proteus and metabolic study of stone came out to be struvite stone. Urethral calculus is a rare form of urolithiasis with an incidence lower than 0.3%. Urethral calculi incidence is high in middle and far east because of incidence of bladder stone. Majority of urethral calculi in men are migrant formed in urinary bladder or upper tract whose passage has been impeded in urethra. Adult men with urethral calculi present with acute retention, frequency, dysuria, poor or interrupted stream and dribbling. Migrant calculi achieves sizable dimension into urethra and often cause acute symptoms. Urethral obstruction can result from inadequate treatment of patient with benign prostate enlargement and bladder stones. Most published reports contain no data on the constituents of urethral calculi. Most of the present calculi (86%) were calcium oxalate, with 6% and 2%, respectively, being struvite and uric acid.

Key words: Spontaneous expulsion, migrant, bladder calculus, urethral fistula, penile ulcer
INTRODUCTION

Spontaneous expulsion of small bladder calculus per urethra or its impaction producing various symptoms ranging from dysuria to acute retention of urine is common presentation for urosurgeons, but bladder stone getting impacted in distal urethra and enlarging to a size > 5 cm is quite rare.

CASE REPORT

A 65 years old chronic alcoholic patient presented 1yr back with features of prostatism and small bladder calculus on USG prostate was 35 cc, bladder calculus size 4mm. X-ray KUB also done. He was given medical management but patient being negligent and non compliant lost follow up, returned to our opd after 1yr with large distal penile urethral fistula and distal penile ulcer following expulsion of solitary calculus measuring 5.5 cm x 3.5cm day before. Patient was passing urine through that fistula & there was no history of passage of urine per rectum. Per rectal examination revealed enlarged prostate with no nodularity. No h/o operation was present. Urine culture showed presence of proteus and metabolic study of stone came out to be struvite stone.
DISCUSSION

Urethral calculus is a rare form of urolithiasis with an incidence lower than 0.3%\(^1\). Urethral calculi incidence is high in middle and far east because of incidence of bladder stone. Majority of urethral calculi in men are migrant formed in urinary bladder or upper tract whose passage has been impeded in urethra. Adult men with urethral calculi present with acute retention, frequency, dysuria, poor or interrupted stream and dribbling\(^2\). Migrant calculi achieves sizable dimension into urethra and often cause acute symptoms. Urethral obstruction can result from inadequate treatment of patient with benign prostate enlargement and bladder stones\(^3\). Most published reports contain no data on the constituents of urethral calculi. Most of the present calculi (86%) were calcium oxalate, with 6% and 2%, respectively, being struvite and uric acid\(^4\).

CONSENT

Written informed consent was obtained from the patient for publication of this case report.

COMPETING INTERESTS

The authors declare that they have no competing interests.
REFERENCES