LETTER TO EDITOR (VIEWERS CHOICE)

FOREIGN BODY IN URINARY BLADDER

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Key words: Foreign body, Urinary bladder, Recurrent UTI

Three years old boy was admitted to our hospital with history of recurrent pain and burning micturation along with passing red color urine. No family history of renal stone, hematuria or deafness was noted. There was no fever. He was completely all right till 2 year of age when he first suffered from dysuria and passing red colored urine for which treatment was taken from a local doctor but symptoms had not decreased so was admitted at a hospital. Details of investigations done at that hospital are not known, however a urinary catheter was placed for 12 days. After discharge from the hospital, he again got recurrent pain during micturation along with passing red colored urine. The attack was relieved by medications but again reappeared every 2-3 months. He also underwent circumcision for the same. On examination, during passing urine, he was in agony with pressing at base of penis and passing red urine with good stream. There was no bulge or swelling noted at the penis. Systemic examination was normal. Urine routine and microscopy showed presence of 25-30 pus cell along with 80-90 RBC/ hpf and traces of albumin. Ultrasound (USG) abdomen showed thickening of urinary bladder suggestive of cystitis. Urine calcium to creatinine ratio was <0.2. Hemogram showed anemia with hemoglobin of 8.3g/dl, total white cell count & differential count were normal with normal platelets. Due to pain at base of urinary bladder, a cystoscopy was done which showed presence of part of catheter in urinary bladder which was removed. Post procedure course was uneventful and on follow up after 15 days, child is well with no complains.

Fig 1 : Piece of urinary catheter removed from urinary bladder

Whenever there is recurrent cystitis we have to find out predisposing cause for it. Though rarely described in children, foreign body in bladder may be the cause for it for which high index of suspicion will be required. Sometimes it can be missed on USG; in such cases cystoscopy may be useful for diagnosis as well as treatment (1). As per definition in NICE Guideline 2007 recurrent UTI is defined as 1 episode of pyelonephritis/upper urinary tract infection (UTI) plus one or more episode of UTI with cystitis or lower UTI or > 3 episodes of UTI with cystitis/ lower UTI (2). In any child with recurrent UTI, identification of predisposing factors is required but most of pediatric book doesn’t mention foreign body as a cause of recurrent UTI. Iatrogenic cause is common but in some it may be self introduced in psychiatric illness or for sexual gratification, or migration from other place (3). In our case it is iatrogenic. There are varieties of objects which can be detected as foreign body like part of Foley’s catheters, broken stent of cystoscope, filiform guide, suture material, gauze piece, fragments of endoscopic instruments other things like metal wire, hair pin, thermometer etc (1,3,4). Two types of symptom complex may be present with this, one as acute retention of urine or one with chronic dysuria, hematuria or recurrent UTI in which cause may be unknown for the years in absence of positive history. In 2nd type the patient most commonly present with dysuria or urinary frequency (4). Our patient presented to us with dysuria and hematuria. Complications of intravesical foreign body consists of chronic and recurrent UTI, acute urinary retention, calcification, obstructive uropathy, scrotal gangrene, vesicovaginal fistula, squamous cell carcinoma and even death due to sepsis (5-8). The diagnosis can be on X-ray if object is radio-opaque or by USG if not radio-opaque. Sometimes, USG can miss the foreign body in that case cystoscopy may be diagnostic and of therapeutic value (1). Now with modern techniques most of the foreign bodies are removed tranurethrally (1,3,4), as was done in our case. Sometimes open surgery may be required.

Conclusion
We are discussing this case as to create awareness that after removal of any catheter one should look that whether it is broken or not. For any persistent or recurrent dysuria or hematuria without any predisposing factors, we have to suspect foreign body along with other causes.

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REFERENCES
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NEUROBLASTOMA PRESENTING AS CHYLOTHORAX

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Key words: Chylothorax, Neuroblastoma, Mediastinal Mass, Respiratory Distress

A four months old male baby was brought to emergency with history of cough and breathlessness for past seven days. On examination child was afebrile, with heart rate - 140/min, respiratory rate - 50/min and blood pressure 70/40 mmHg. SpO2 was 70% on room air which increased to 92% with 100% oxygen. Respiratory examination showed marked intercostal and subcostal retractions with decreased air entry on the right side of chest. Rest of the systemic examination was within normal limits. X-ray chest showed evidence of pleural effusion with a well defined large heterogeneous lobulated mass containing coarse calcifications in right thoracic paravertebral region. (Fig. 1) Provisional diagnosis of pleural effusion was made and supportive therapy was started with oxygen supplementation, intravenous fluids and parenteral antibiotics. To relieve respiratory distress, intercostal tube drainage was performed, through which milky white fluid was drained which was sent for analysis. On analysis, specific gravity of pleural fluid was 1.012; leukocyte count was 5000/µL with 90% lymphocyte, while the triglyceride and cholesterol content were 220 and 50 mg/dl respectively. Lipoprotein electrophoresis of fluid showed a chylomicron band. All these investigations were conclusive of chylothorax. Contrast enhanced CT chest revealed a large (5.3x5.8x7.5 cm) well defined heterogeneous contrast enhancing mass containing coarse calcification in paraspinal region of upper half of thorax, extending into spinal canal (T2-T5) and displacing the mediastinal structures (Fig. 2) suggestive of neoplastic etiology (most probably neuroblastoma). CT abdomen and head were normal. CT guided fine needle aspiration cytology (FNAC) showed few sheets of small monomorphic round cells with hyperchromatic nuclei having evenly distributed chromatin without prominent nucleoli associated with...