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A Rare Complication during Stricture Urethra Surgery.

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ABSTRACT

Surgeries for stricture urethra are associated with high complication rates the commonest being restricture. A 62 yr old obese male patient with history of ten previous surgeries for urethral stricture and on supra pubic cystostomy was taken up for urethral dilatation surgery under Asa grade 2 under subarachnoid block. During the course of surgery the patient developed difficulty in breathing chest discomfort and heaviness in abdomen, desaturation with stable hemodynamics and no ECG changes. The cause for this was found to be fluid collection between the abdominal muscles and peritoneum which was drained and the patient's condition improved immediately and post-operative period was uneventful.

Keywords: surgery, urethral dilation, complications

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INTRODUCTION

The commonest causes of stricture urethra are trauma and infection. The commonest surgeries performed for this condition are urethral dilatation, internal urethrotomy, excision of the scar and primary anastomosis (end-to-end anastomosis of tissue), free graft (skin, mucosal lining of cheeks, outer layer of bladder), island flap of penile skin or of foreskin, scrotal island flap, combined tissue transfer (combination of the above techniques). These surgeries are fraught with high complication rates. The commonest complications are restricture, thromboembolism, nerve injuries due to positioning, bleeding, fistulous tract formation, infection, wound breakdown, tightness with erections (generally temporary), dribbling, and other complications. When these patients present with acute retention it is common practise to do a suprapubic cystostomy and then electively post them for reconstructive surgery.

In our case report we present one such patient who had many repeated surgeries for urethral stricture. Last he underwent a suprapubic cystostomy and was taken up for reconstructive surgery during which there was a rare complication.

Case Report

A 62yr old male who had undergone repeated surgeries for urethral stricture, with suprapubic catheter in position had come for urethral dilatation.

On evaluation, the patient was obese and had no other co-morbid illness. All his lab investigations, ECG, chest X ray and echo were within normal limits. Patient was taken up for surgery under ASA II under subarachnoid block with 2.5cc of 0.5% bupivacaine heavy with 20µg of fentanyl in L3 L4 interspace. Block was found to be adequate (level of block was T8). The patient was positioned in lithotomy position and surgery was started.

The surgeon had great difficulty in passing the scope urethrally and hence inserted the scope through the SPC (suprapubic cystostomy) puncture and tried visualising the urethra from above. During this time (approx.30 to 40min from start of surgery) the patient started complaining of difficulty in breathing and later heaviness of the abdomen. His saturation started to drop. The patient was hemodynamically stable and there were no ECG changes. The patient was sedated with inj.pentazocine 15mg IV. But inspite of this his discomfort was not relieved. The level of block was rechecked and found to be adequate.

The surgery was abandoned and the patient was repositioned in supine position with 30° head up tilt. On examination his abdomen was found to be mildly distended and was dull on percussion. The return fluid was also less.

The patient continued to have difficulty in breathing and his saturation did not pick up. He was assisted with 100% O2 with bag mask, following which saturation picked up. Ultrasound abdomen was taken and fluid collection was detected between the abdominal muscles and peritoneum.

Then a needle was inserted in the flanks by the surgeon and almost 6 litres of fluid was drained following which the distress was relieved and saturation picked up and vitals were stable. He had an uneventful postoperative period was discharged on the 5th postoperative day.

DISCUSSION

Urethral stricture presents as real challenge to the urologist as its surgical procedure is not only difficult but is also associated with high complication rate, the commonest being restricture. Our patient had undergone many surgeries previously for urethral stricture and was on suprapubic cystostomy.

Suprapubic cystostomy is a relatively simple and quick procedure which is commonly done in these patients when they present with acute retention. It is commonly done as a blind, percutaneous surgery with serial dilatation over a guide wire.

There have been various accounts of different complications following this surgery such as kinking of guide wire, breaking of guide wire, blockade of tube, perforation of ileum, scrotal and subcutaneous emphysema. Though ours is a urethral dilatation surgery and not a suprapubic cystostomy surgery the complication was due to an iatrogenic fistulous tract in the suprapubic cystostomy tract.

Due to the old age of our patient and the masking of the abdominal distension in the initial stages by his obesity we were prompted to think in the lines of myocardial infarction and spinal anaesthesia complications when he complained of breathlessness. Only when we had ruled out these causes and abdominal distension was more pronounced we started thinking of a surgical complication as a cause for his chest discomfort [1-8].

We present this case report to sensitise people to think out of the box and also to anticipate more complications in resurgeries and hence be ever watchful of the surgical field in such surgeries (always have a careful watch over the quantity of return fluid).

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