DYSPAREUNIA DUE TO A BLADDER STONE

(A Case Report)

by

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The proximity of the urinary tract to the organs of reproduction makes it inevitable that there should be a great deal of overlap between the two systems, and hence a gynaecologist, therefore, to some extent has to be his own urologist as well.

In the field of differential diagnosis there must be many pitfalls, specially in the matter of abdominal pain with indefinite physical signs, reflex intestinal disturbances, or a vague dyspareunia.

Vesical calculus complicating pregnancy and labour has been reported by Seetha *et al* (1967). Cope (1961), while reporting his case of vesical calculus causing obstructed labour, has stressed on the rarity of its occurrence in the female. Its incidence is in the ratio of 50:1 as compared to male and female (Ian Aird 1957). A case of vesical calculus giving rise to gynaecological symptoms is presented here:

Case Report

S. J., aged 30 years, was admitted in Cantonment General Hospital on 14-10-67 with the complaint of pain in the lower abdomen for 3 days followed by loose motions since the day previous to her admission. She was transferred to Command Hospital, Poona, on 1-11-67 for further investigation and treatment after her initial acute symptoms had subsided. Her menarche was at the age of 14 years; her cycles had been very regular and her last period was 15 days back. She got married only six months ago and she could not lead her marital life because of severe dyspareunia. The hesitancy in passing urine dated back one year, with occassional passage of milky white urine. During this period she had been catheterised twice, for obstructive anuria. Her childhood and adolescence had been uneventful. She had a suprapubic cystic, tender, swelling rising two inches above the symphysis pubis.

Per vaginam examination revealed that there was a tender firm mass pushing down the anterior wall of the vagina. The cervix could not be palpated and the total length of the vagina was hardly about an inch and a half. Uterus was anteverted, mobile, normal in size and felt behind the mass only after the bladder was catheterised. There was a brownish discharge per vaginam.

Per speculum the cervix was not visualised. A provisional diagnosis of ovarian tumour incarcerated between uterus and bladder was made. The true diagnosis was revealed only after an x-ray examination. An opaque shadow, oval in shape, was detected at the bladder site (Fig. I). The presence of calculus was confirmed by sounding the bladder. Catheterisation brought out about 15 oz. of urine of milky white colour. A culture of urine revealed E. coli infection. She had mild leucocytosis of 11,200 per cubic millimeter, with poly 80%, lympho 18% and eosino 2%. Her blood urea was 42 mg%. She was running a low grade temperature, ranging between 100-101°F on admission. She was put on a binding mixture for her diarrhoea and

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when her diarrhoea stopped she was put on streptomycin injections. When her temperature became normal and remained so for about 7 days, an intravenous pyelogram was done which revealed a very mild degree of pressure effect on both kidneys (Fig 2).

A suprapubic cystolithotomy was done on 22-11-67, and a stone measuring 9" x 2.5" was brought out (Fig. 3). A fair sized diverticulum was detected at the base of the bladder where the stone was lodged. The suprapubic cystotomy wound was closed in layers and continuous bladder drainage was carried out with Foley's catheter for 10 days. The patient developed pseudomonas pyocyaneous infection post-operatively and was treated with polymyxin to which the organisms were susceptible. A month later a cystogram was done which showed that the diverticulum was still present, but had shrunken considerably in size. Unfortunately, this particular x-ray plate had been misplaced and could not be produced. However, the patient is asymptomatic now.

Comments

The commonest calculus seen in the bladder is phosphatic in origin, and it is thought that its formation is mainly due to the presence of a congenital diverticulum in the bladder. Symptoms of reflex intestinal disturbances, which this patient presented with, are fairly common in cases of urinary infection. Dyspareunia in this case was of urological origin. The calculus must have formed in this case in childhood. But as the bladder stone increased very slowly and silently without producing any symptom, the patient did not seek any medical advice. A casual and transient urinary symptom is disposed of as a minor ailment. In the present case the patient probably would not have sought medical advice had she not found that she could not lead her useful marital life. That this stone had spared the kidneys and ureters of gross hydronephrotic changes was due to the mobility of uterus within the pelvic cavity and the adaptability of bladder to "over crowding" and lastly to its accommodative property.

However, it must be remembered that the recurrence of another stone is a very real danger in this case if the shrunken diverticulum does not disappear completely. If the diverticulum is still present six to eight months after the operation its removal is indicated.

Summary

(1) A case of bladder stone admitted with a history of diarrhoea and dyspareunia is reported. The calculus was removed and her symptoms have disappeared since then. The cause of stone formation in this case was a diverticulum of the bladder and the danger of recurrence, if the diverticulum is not removed, is stressed.

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See Figs. on Art Paper VI