TRUE INCONTINENCE OF URINE DUE TO SEVERE CHRONIC CYSTO-URETHRITIS

(A Case Report)

by

B. SARKAR

SUMMARY

True incontinence of urine commonly occurs due to acquired genito-urinary fistulae and rarely due to congenital abnormality like uretero-vaginal fistula, epispadias or ectopia vesicae. Cystitis generally causes urge incontinence, but here is a case where true incontinence developed due to severe chronic cysto-urethritis.

Case Report

Mrs. M. B. P., 26 years old, para 1 + 0, was admitted for continuous involuntary dribbling of urine for the last 2 years. She gave the history of prolonged labour and was delivered by caesarean section 2 years ago. Ten days after the operation incontinence of urine started.

A thickened mass with tenderness was felt through the anterior fornix. Culture of urine could not be done as there was no arrangement in the Hospital. Blood urea was 30 mg%. I.V.P. including cystogram showed reduced capacity of urinary bladder; kidneys and ureters were within normal limits and both the ureters ending in the bladder (Fig. 1). But no dye was seen in the urethra, which is in contrast to the symptomatology.

Small filling defects or cobble-stone appearance due to oedematous m.m. was not visible in the cystogram probably due to heavy concentration of radio opaque dye in the cavity (Fig. 1). Only 10 c.c. of 1% gentian violet could be introduced through the rubber catheter into the bladder cavity which regurgitated out with frank blood. None of the three swabs kept in the vagina was stained by the dye, nor the uppermost one got wet by the ureteric urine revealing absence of any genito-urinary fistula.

From: Deptt. of Obstetrics and Gynaecology, North Bengal Medical College, Siliguri, Dist: Darjeeling.

Accepted for publication on 21-5-86.

On bimanual examination under G.A. whole thickened bladder mass could be palpated. Micturating cysto-urethrography, cystometry and cystosocopic examination could not be done.

As no urogenital fistula could be detected and from the bladder findings we came to the conclusion that the incontinence of urine was due to severe chronic cystourethritis leading to "automatic bladder" without any specific neurological lesion, where little amount of urine which was collected in the bladder came out spontaneously without the knowledge of patient. Therefore, the treatment was directed accordingly. Continuous drainage of the bladder by the Foley's catheter. Antibiotics were given for two weeks. After two weeks of continuous drainage, bladder was drained 2 hourly for 2 days, thereafter 4 hourly for 3 days and then catheter was removed. Now she could hold urine for 30 minutes only and could pass urine per via naturalis. She was then put to 'bladder drill' and co-trimexazole (Bactrim—DS) 1 tab. BDPC x 1 month and biological stimulant inj. placentrex i.m. on alternate days x 15 such were given. After 6 weeks of this treatment the patient could hold urine for 2-3 hours and on bimanual examination bladder mass was found to be just palpable with little tenderness. Then on 16-3-1984 I.V.P. with cystogram was repeated which showed relatively increased capacity of the bladder (Fig. 2). The patient was discharged on 23-3-1984 and on monthly follow-up for six months improvement in her urine-holding capacity was observed.

See Figs. on Art Paper VI