An unusual case of urethral incontinence 
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Patient A came to us with c/o involuntary loss of urine 
since 3 years. The urine loss was initially small in amount 
and was more during physical exertion. There was no h/ 
o bed wetting. After her last delivery I year ago, urinary 
leak increased in amount & even during normal physical 
activities and on changing posture. She felt wet at all 
time. 
MH-RNF LMP-I 0 days back 
OH-3FTND LD-I year. All home deliveries. 
flated balloon was expelled from dilated urethra 
which admitted 2 fingers. Finger went easily into 
the bladder. No resistance was felt at internal 
sphincter. A provisional diagnosis of transurethral 
incontinence was made. 
On repeated questioning, the couple admitted to the pos-sibility of urethral intercourse. Urologist also opined that 
incontinence was due to dilated urethra & loss of sphinc-teric action was due to urethral intercourse. 
0/E She was fairly built & nourished. Her vital pa-Urethral reconstructive surgery by Young & Dee~ 
rameters were settled. Method with urethroplasty & abdominal sterilization was 
On local exam -ext. genitalia were normal and 
wet. Ext. urethral meatus was patulous through 
which few drops of urine came out on straining. 
P/S-cervix & vagina healthy. PlY ex\); ut RVRF 
N/S F/M Fx Free. No fistulous opening seen in 
vagma. 
Three swab test performed but Foley's catheter with in-TilE JOURNAL OF OBSTETRICS AND GYNAECOLOGY OF INDIA 
done. 
Ureteric catheters, drain in Space of Retzius and tran-surethral catheters were removed on 5th, 7th and 20th 
POD respectively. Malecot's catheter was clamped in-termittently to allow patient to void urine & was removed 
on 22nd POD. Patient was discharged on 28th POD. 
She had regained complete control on micturition.