To the Editors:  

Outcome of anastomotic urethroplasty in bulbomembranous urethral strictures

Poorly managed traumatic bulbomembranous urethral strictures could have a devastating effect on the quality of life. Until recently this problem was poorly managed in Sri Lanka, condemning some patients to lifelong suffering with unsettled lower urinary tract obstructive symptoms and infective complications. The commonest primary injury is pelvic fracture. A complete urethral rupture associated with pelvic fracture mostly ends up in a urethral stricture [1], demonstrable as a total discontinuity of the urethra in contrast urethrography. A segment of bulbomembranous urethra undergoes spongiosfibrosis and gets replaced with fibrous tissue, so that less invasive treatment modalities such as urethral dilation and endoscopic incision of the stricture (optical urethrotomy) yield a poor outcome. Excision of the stricture followed by end-to-end anastomosis seems to be a logical solution to this problem in spite of its complexity and the higher demand on surgical skill [2]. There are no published local data on this technique. The present study describes the initial outcome of this procedure carried out by the author in a tertiary urological referral center.

The study comprises a retrospective review of 46 patients who underwent anastomotic urethroplasty from January 1997 to December 2001. All patients were males, between 7 and 58 years of age. Pelvic fractures (road traffic accidents in 36, falls in 5) was the cause in 41 patients. The others were inflammatory in origin compounded by blind instrumentation. Before referral several patients had undergone surgical procedures such as urethral dilation (8 patients), optical urethrotomy (12), railroading urethral realignment (5) and endoscopic realignment (4) without success. Thirty eight patients were with a long term suprapubic cystostomy. Patients were scheduled for surgery 4 to 6 months after injury was assessed with basic renal function tests, ultrasound urodynamography, combined ascending and descending urethrography and urethroscopy (only when suspected to have multiple strictures). The procedure was carried out under general (11/46) or spinal (35/46) anaesthesia in an exaggerated lithotomy position. The bulbomembranous urethra was approached transperineally (39/46) in combination with supra-pubic exposure (7/46). After dissecting and defining, the stricture segment (5–25 mm in length) was resected and end-to-end anastomosis was achieved in 42 patients. Due to technical difficulties a urethral pull-through technique was used in four patients [4]. A urethral catheter was in place for 10 to 14 days. Following the catheter removal and passage of urine, a blocked supra-pubic catheter was left as a safety valve for 3 months. Patients were asked to report immediately in case of poor urinary stream. Otherwise they were assessed by uroflowmetry in 6 to 12 weeks and post-operative urethrography in case of suspected repeat stricture. The supra-pubic catheter was removed after 3 to 6 months in patients who did not show any evidence of stricture.

Thirty eight (82%) patients were judged cured at the end of a follow up period of 8 to 60 months when there was no evidence of stricture recurrence. Eight patients had varying degrees of restenosis at the anastomotic site which needed regular optical urethrotomy and dilation (5/8), repeat urethroplasty (3/8) and Mitrofanoff appendicovesicostomy urinary diversion (1/8). Complications also included primary haemorrhage which required blood transfusion (3 patients), perineal haematomata, infection and wound dehiscence (1), erectile failure (5) and stress incontinence (3) and rectourethral fistula (1). Complication rates compared well with other studies [6].

The cure rates were encouraging in a condition which was notoriously difficult to manage because of marked fibrosis of the urethra. In traditionally used urethral dilation and endoscopic urethrotomy only one-third of strictures get cured and the subsequent urethroplasty of the failures would be technically more difficult as a result of increased periurethral fibrosis [3,5]. Although not universally accepted, local excision of the stenotic segment and end-to-end anastomosis seems to be the treatment of choice, with cure rates close to 100% in some studies [5]. While short (<1cm), well aligned strictures would still respond to lesser procedures, with present experience we recommend anastomotic urethroplasty for recurrent (after two attempts of dilation or endourethrectomy), long and malaligned strictures. Our results also emphasise the fact that pelvic fractures associated with posterior urethral injury should be best managed initially with supra-pubic drainage followed by referral to a specialised unit for the management of the resulting stricture.

References

Factitious disorder (FD) is the intentional production or feigning of symptoms or disabilities either physical or psychological [1], usually without obvious motivation such as financial compensation or escape from danger. At times the motivation is to receive medical care or to take the sick role [2,3]. Malingering (M) is the intentional production or feigning of either physical or psychological symptoms or disabilities, motivated by external stress or incentives [1,2]. A case of a child subjected to abuse and who presented with pseudo-convulsions prompted us to write this response along with two other cases, to focus on the implications of making these diagnoses [4].

Case 1

A 24-year-old single woman was referred from the dermatology unit with a history of multiple skin eruptions for 3 years. She had also been investigated for ear discharge and seizures. She was the seventh of the nine children from a poor family. Her mother left home when she was 9 and the father died when she was 11 years. She had witnessed constant marital conflicts and never had a close relationship with a man. She lived in a hostel and worked as a factory helper. Her earnings were less than an average worker due to frequent absenteeism.

An initial diagnosis of FD was made using ICD–10 [2]. A decision was made to offer psychotherapy and continue exploring her symptoms. Later, an association between pressure from family to marry and a fresh crop of skin eruptions emerged. Sensitive probing revealed that she was subject to repeated incest by her brother from the age of 8. She was reluctant to visit home because there was pressure to marry and memories of past sexual abuse. To escape from the situation, she burnt her body by using hot oil and a liquid detergent. Her diagnosis was reviewed because the underlying cause seemed to be her dislike and fear of marriage. The alternate diagnosis to FD was M, which was even more stigmatising. A decision was made not to use a diagnostic label but to continue to see her and offer supportive therapy. Three years later, she is married, and visits the unit socially.

Case 2

A single woman from an orphanage was referred for assessment of discharge from the ear and nose and repeated fits for 6 months. These episodes confined her to hospitals for long periods. She was suspected to have a FD.

Further discussion revealed that she was orphaned as a child, when both parents died from a terrorist bomb blast. She was brought up in an orphanage and was now expected to move on and find her own living. There was increasing pressure from members of an armed militant group to join the movement, which she resisted. She felt vulnerable and trapped. She said that she inflicted injuries that caused the discharge or had fits when she felt frightened about her future. In hospitals she found a temporary escape. She improved with psychotherapy and was transferred to another hospital for follow up.

The FDs are characterised by feigned physical or psychological symptoms and signs presented with the aim of receiving medical care [3]. For firm diagnosis of FD, direct evidence of production of these symptoms and exclusion of other causes are necessary. Malingering has to be distinguished from FD. In M there is usually an external motive that is obvious [2]. Malingering is not a diagnosis of a disease, but a behaviour. These differ from somatoform disorders, where the symptoms are medically unexplained but are not deliberately produced [5].

In both our cases the diagnosis changed from FD to M. This illustrates the need to give adequate time before a firm diagnosis is made of such disorders. More importantly, we wish to question the appropriateness of these diagnostic categories in the current ICD classification. Both entities confer culpability on the person who is trying to escape a stressful situation. They are merely cries of desperation of those struggling to survive amidst social cruelty. Furthermore, the label implicitly encourages stigmatisation. Doctors need to avoid taking on the role of detectives searching for diagnostic labels and compound the suffering of those who manifest such symptoms. Instead the focus should be to manage their symptoms, explore their beliefs and show empathy. It is best not to classify them as FD or M but under “factors influencing health status and contact with health services (ICD-10: Z00-Z99)”, as a new entity known as “maladaptive coping strategies to survive”. From the above cases we have tentatively identified the following criteria for inclusion in this category:

a) The presence of a life-threatening or extremely stressful or unpleasant situation, with no perceptible escape.