Iatrogenic Stone Formation on Absorbable Suture Following Radical Retropubic Prostatectomy in an Elderly Patient

Yaşlı Bir Hastada Radikal Retropubik Prostatektomi Ameliyatı Sonrası Sütür Materyali Üzerinde Taş Gelişimi

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INTRODUCTION

Urethral calculi is a rare condition and it usually develops by migration of a bladder calculus. But calculus formation primarily in the urethra may develop due to an obstructive cause either congenital or acquired. In this case we present a patient having urethral calculi secondary to a postprostatectomy suture material in a elderly man.

CASE REPORT

The 66 year old patient had undergone radical retropubic prostatectomy in 2004. He neither had urinary incontinence nor signs of infravesical obstruction during the routine controls in the postoperative period. He admitted to our outpatient clinics with the complaints of dysuria, frequency, poor urinary stream,
feeling of residual urine and dribbling. Obstructive uroflowmetric pattern was detected (Figure 1). Mild ureterohydronephrosis and a hypoechoic mass just distal to the bladder neck were detected in the ultrasound scan. The patient is evaluated with urethroscopy and urethral calculi developing on the basis of suture material is detected in the posterior urethra. The calculus is taken out with the foreign body forceps (Figure 2A, 2B).

DISCUSSION
Urethral calculi is uncommon; the majority is of upper tract or bladder origin and migrates into the urethra (1). They are estimated to represent 0.3% of all urinary stone diseases (2). Urethral stones are reported to be relatively more frequent in childhood, particularly in developing countries, because of the high prevalence of bladder calculi. Most of the present calculi (86%) were calcium oxalate, with 6% and 2%, respectively, being struvite and uric acid (3). Some authors consider that urethral stones are usually radiolucent and that a uroradiographic diagnosis is made in only 40% of cases (3,4). These stones can be classified as either migrant or native with the former being responsible for roughly 90% of all stones. Migrant stones originate in the bladder or upper tracts and generally become impacted in the posterior urethra (5). Native urethral stones may develop with associated anatomic abnormalities or postsurgical changes (5). In

![Figure 1. Obstructive uroflowmetric pattern.](image1)

![Figure 2A. The calculus at posterior urethra.](image2)

![Figure 2B. The calculus is taken out with forceps.](image3)
general, the most common abnormalities associated with urethral stones include foreign bodies, urethral strictures, diverticula, and chronic infection (5,6). Like this present, rarely it can be seen on absorbable suture after radical prostatectomy (7,8). Treatment of the urethral stones mostly depends on the anatomic location and the width of the stone and on the associated anatomical pathology of the urethra. Milking, forceps extractions (manual or endoscopic) or basket, endoscopic push-back, electrohydraulic lithotripsy and surgery (internal urethrotomy, meatotomy, percutaneous and open cystolithotomy) are the treatment options (2).

REFERENCES