American Journal of Medical Case Reports, 2017, Vol. 5, No. 9, 254-255
Available online at http://pubs.sciepub.com/ajmcr/5/9/8

DOI:10.12691/ajmcr-5-9-8

A Case Report: Vaginal Cystolithotomy on a Patient with Pelvic Organ Prolapse and Multiple Vesical Calculi

Trika Irianta*, Elisabeth Tanuwidjaja

Department of Obstetrics & Gynecology, Urogynaecology & Pelvic Reconstructions Division,
University of Hasanuddin, Makassar-Indonesia
*Corresponding author: trika_irianta@yahoo.com

Abstract Vesical calculi are not commonly seen with pelvic organ prolapse. We report a case of a 64 years old multiparous woman, who presented with history of vaginal mass in the last 2 years. Gritty sensation was felt on palpating the cystocele and multiple calculi were suspected intraoperatively. A transvaginal hysterectomy was done followed by vaginal cystolithotomy, an anterior colporrhapy and posterior colpoperineorrhapy (Mc call culdoplasty technique). Multiple vesical calculus was removed. Post-operative course was unremarkable.

Keywords: *vesical calculi, pelvic organ prolapse, vaginal cystolithotomy*

Cite This Article: Elisabeth Tanuwidjaja, and Trika Irianta, "A Case Report: Vaginal Cystolithotomy on a Patient with Pelvic Organ Prolapse and Multiple Vesical Calculi." *American Journal of Medical Case Reports*, vol. 5, no. 9 (2017): 254-255. doi: 10.12691/ajmcr-5-9-8.

1. Introduction

The coexistence of pelvic organ prolapse and vesical calculi is a rare case. It presents diagnostic dilemma and operative challenges to the managing team because of its rarity. [1]

2. Case Report

A 64 years old multiparous, post-menopausal woman for 20 years presented with mass coming out from her vagina for 2 years which gradually increased in size. She complained frequency of micturition with dysuria and leakage triggered by cough for the last 1 year.

She has been married for 48 years with six children. All children were delivered fullterm at home.

On examination, she was clinically pale. On physical examination, her vital signs were stable and no mass palpable per abdomen. Local examination revealed forth degree utero vaginal prolapse, third degree cystocele, third degree rectocele and prolapse rectal (Figure 1). Upon further examination lab results revealed that the patient has anemia. Her hemoglobin was 8 g/dl. Other laboratory results were serum creatinine 1.4mg/dl (slightly increased), blood sugar level was within normal range. Urine examination was not done. Whole abdomen ultrasound revealed difficult to assess.

Transvaginal hysterectomy was performed first followed by vaginal cystolithotomy for which a midline vertical incision was done at the fundus of the bladder, then multiple stones were drawn out. (Figure 2 & Figure 3)

The bladder was closed in two layers using Polyglactin 910 suture no.3-0. After the repair of the bladder, an anterior colporraphy and posterior colpoperineorrhapy (Mc call culdoplasty technique) was performed.

Postoperative, patient was stable and planned for referral to Digestive surgery for further management of her rectal prolapse (Figure 4).

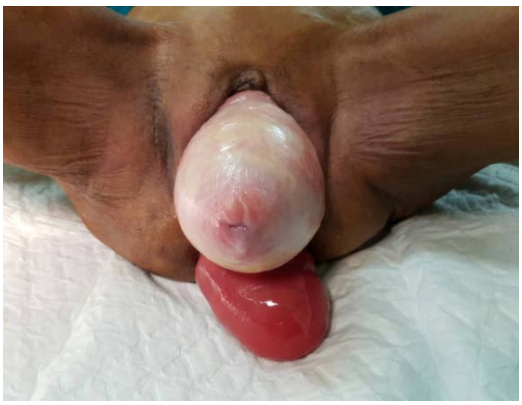

Figure 1.

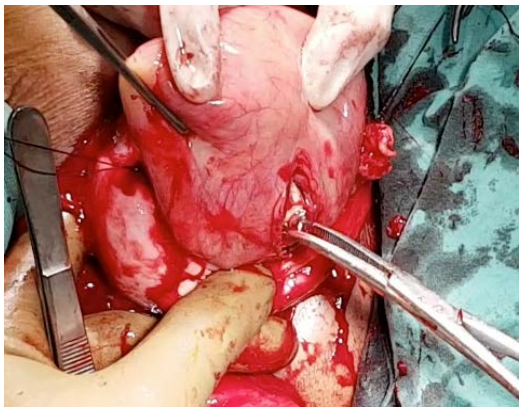

Figure 2.

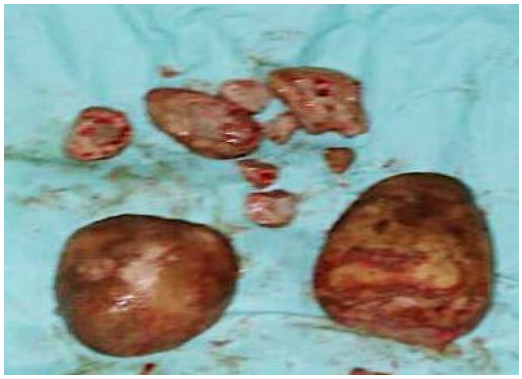

Figure 3.

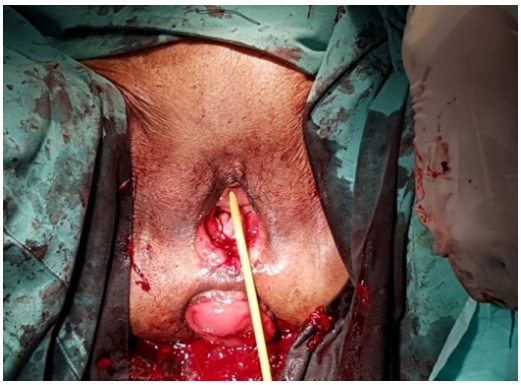

Figure 4.

3. Discussion

Vesical calculi are stones or calcified materials that are present in the bladder. Vesical calculi are commonly found in men, but involve only less than 2% of women. The association of vesical calculi and prolapse is rare. Although the etiology of vesical calculi remains unknown, the literatures said predisposition factors are urinary stasis and infection. [2]

The presence of vesical calculi should be considered in the setting of an irreducible pelvic organ prolapsed. Missing diagnosis of calculus could lead to complications due to progressive damage and operative difficulties [3]. We should have a well thought pre-operation diagnosis before doing the procedure. Basic steps such as a thorough history taking including the patient's history of micturition, presence of symptoms like dysuria with passage of stones upon voiding should be added for a complete history [2]. Diagnostic procedures such as the pelvic and KUB ultrasound, pelvic x-ray, abdominal CT scan and MRI would be beneficial. The patient should be maintained on indwelling foley catheter postoperatively for 7-10 days and should be prescribed with antibiotics. The patient should also be advised to drink a lot of water.

Retrieval of vesical calculus could be done by suprapubic incision or vaginally. Suprapubic incision minimizes subsequent vesicovaginal fistula formation and would have less morbidity [4].

4. Conclusion

This case has enlightened us that in any case of an irreducible pelvic organ prolapse, a possibility of vesical calculus should be kept in mind. A vaginal cystolithotomy procedure can be safely performed with a vaginal hysterectomy.

References

[1] P BASNET, A. A., A THAKUR, DK UPRETY, R BHATTA, S KOIRALA 2014. Multiple vesical calculi complicating uterine prolapse. *Health Renaissance*, 12, 55-56.

[2] DWYER, K. S. A. P. L. 2012. Urinary Bladder Stones in Women. *CME Review Article*, 67, 715-725.

[3] RAMAN, S. C. A. S. 2014. Vesical Calculi with Utero Cervico Vaginal Prolapse. *Global Journal of Medical and Clinical Case Reports*, 33-34.

[4] PUSHPA DAHIYA, A. G., KRISHNA SANGWAN 2007. Multiple bladder calculi: a rare cause of irreducible uterine prolapse *Arch Gynecology Obstetrics* 275, 411-412.