Omission of Postoperative Cystoscopic Assessment May Be Hazardous: A Case Report of Bladder Injury Secondary to Laparoscopic Burch-type Colposuspension

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Careful and systemic cystoscopy must be performed following any vaginal, abdominal, or laparoscopic type incontinence operation. Herein, we present a case of a patient suffered bladder perforation, a potential complication of laparoscopic intervention, which could have been easily prevented or managed intraoperatively. On account of this occasion, the significance of check cystoscopies after incontinence operations is revisited.

Case report

A 47-year-old woman was referred to our outpatient clinic in March 1998 complaining of severe dysuria, frequency, dyspareunia, and occasional macroscopic haematuria. Her symptoms had arisen acutely following a Burch-type laparoscopic colposuspension performed for genuine stress urinary incontinence by a gynaecologist in December 1997. She had been on oral antibiotics for a recently documented postoperative urinary infection.

At presentation, clinical examination was unremarkable, except for suprapubic discomfort. Haematuria and pyuria were present under microscopic urinary examination. Plain radiograph of the abdomen showed multiple helical opacifications localized around the pubic region (Fig. 1). Ultrasonography revealed a hyperechoic, immobile, metallic image within the posterior wall of the bladder.

The patient underwent diagnostic cystosco-urethroscopy under general anaesthesia. An endoscopic tacker (Guidant-Origin, USA) was easily observed inserting through the right side of the dome into the trigone at a few millimetres posterior to the right orifice and uplifting the bladder base. The left ureteral orifice was not visible at cystoscopy. During the subsequent open surgical exploration of the bladder it was found that two additional titanium tackers perforated the left lateral wall, and attaching it to the trigone at just 2 mm medial to the left ureteral orifice. After catheterization of the ureteral orifices, each tacker was meticulously dissected from the bladder wall, and the mucosa was repaired by using 4-0 polyglycolic acid sutures (Fig. 2). A cystostomy tube and a perivesical sump drain were placed prior to closure.