

Correspondence

Any hint for urinary bladder injury after operation

To the Editors:

We read Ko and colleagues' report, entitled "Urinary ascites with elevated blood creatinine following cesarean section indicating bladder injury", with interest [1]. The authors presented a highly instructive case report—that of urinary ascites with elevated blood creatinine that occurred in a 37-year-old woman who underwent a repeat cesarean section on the 3rd day postoperatively. We congratulate the authors for their rapid and appropriate treatment of the patient. Their efforts not only saved this patient's life, but also avoided potential morbidity and other future problems.

Based on our limited understanding, the typical clinical course of urinary ascites after pelvic surgery was demonstrated clearly, including the gradual but persistent increase in abdominal pain, exacerbated abdominal fullness, and progressive difficulty in voiding, leading to abdominal distension and dyspnea accompanied with intermittent, severe, colicky abdominal pain. At this time, any physician could easily identify the unusual symptoms in this patient, that is to say the occurrence of acute abdomen and intra-abdominal emergency, which explained why this patient was transferred to the medical center for further management on the 3rd day after cesarean section. However, some questions regarding this case report are raised and we hope that they will be addressed.

Acute abdomen associated with dyspnea suggests an urgent condition that might hint at the presence of a life-threatening situation [2,3]. We wonder why this patient did not have a urinary catheter to monitor her input and output at the initial stage of treatment. According to the case report, intravenous fluids were reinstated in the emergency room, and a urinary catheter was inserted, with drainage of 2000 mL of urine [1]. In addition, the initial blood creatinine level was high, up to 7.94 mg/dL, which suggested the possibility of acute renal function impairment. That is why the authors said that abdominal-pelvic computed tomography (CT) with contrast-enhancement was contraindicated. The examination chosen, CT without contrast-enhancement, might contribute to a failure to identify the urinary bladder injury because it is much easier to identify the site of bladder injury using abdominal-pelvic CT with contrast-enhancement [1]. We also wonder why an antibiotic with relatively high renal toxicity, such as gentamycin, was prescribed for this patient if the authors had considered the possibility of acute renal function impairment [4].

Furthermore, urinary ascites is not always caused by bladder injury; therefore, urinary tract injury might be more appropriate for the title of this case. Finally, if insertion of a urinary catheter could restore renal function, based on the authors' description, the biochemical analysis of her blood revealed creatinine 0.75 mg/dL and the dramatic change in creatinine and estimated glomerular filtration rate, and most importantly, urinary output could be maintained by this strategy, long-term use of a urinary catheter could be considered in place of exploratory laparotomy for urinary bladder repair.

We should emphasize that our questions cannot be considered to dispute the successful treatment of this patient, since the clinical condition is always changing and any treatment should be individualized, although some guidelines can be followed [5,6].

References

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