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CASE REPORT

Recurrent bladder exstrophy following cystolithotomy

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Case report

An 8-year-old girl with a repaired bladder exstrophy and continued urinary incontinence after bladder neck reconstruction was referred for further management. She had severe mental retardation and re-operative bladder neck surgery was not recommended. Subsequently, she developed a massive bladder stone (Fig. 1) for which open cystolithotomy was performed under appropriate antibiotic cover. Three weeks later, the bladder dehisced completely which could be best described as a recurrent exstrophy. She did not return for a follow-up examination for 1 year, when extensive squamous metaplasia of the exstrophy was noted (Fig. 2). The ureteric orifices were stenotic and ultrasonography showed bilateral ureterohydronephrosis when previously the kidneys were normal. Cystectomy with double-barrelled ureterostomy was performed, after which her progress was satisfactory.

Comment

The management of female bladder exstrophy entails closure of the bladder with or without osteotomy followed by an incontinent interval. Subsequently, bladder neck reconstruction is undertaken to provide continence, but reoperation is sometimes necessary [1]. This was not considered advisable in the present patient with severe mental retardation and continuing incontinence, as she would not have permitted clean intermittent catheterization.

Patients with repaired exstrophy are prone to bladder calculi, usually secondary to poor bladder emptying, urinary infection and possibly a suture nidus [2]. Wound dehiscence after exstrophy closure may be caused by calculi [3], but recurrent exstrophy following cystolithotomy years after successful exstrophy closure is a unique complication.

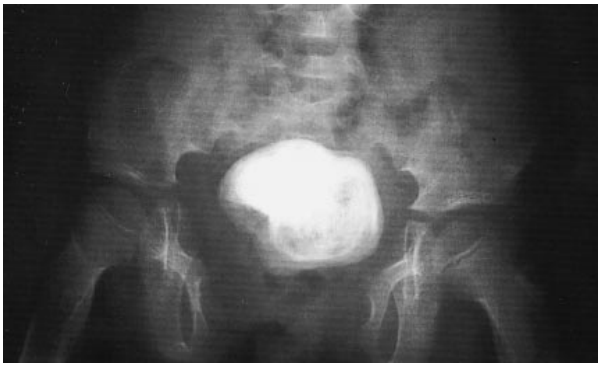

Fig. 1. Abdominal radiograph showing the large bladder stone.

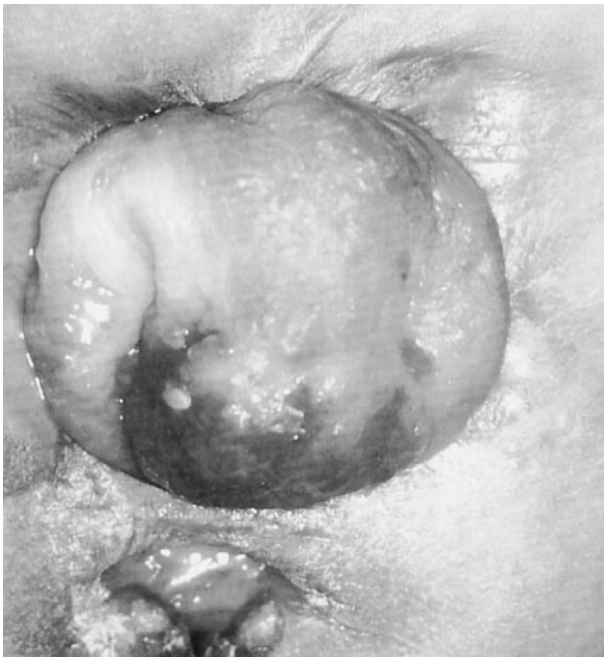

Fig. 2. Recurrent bladder exstrophy with severe squamous metaplasia.

References

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3 Lowe FC, Jeffs RD. Wound dehiscence in bladder exstrophy: an examination of the etiologies and factors for initial failure and subsequent success. *J Urol* 1983; **130**: 312–5

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