
RESIDENT'S CORNER

Urethral foreign body insertion for secondary gain in the incarcerated population

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Not uncommonly, hostile prison environments can lead desperate prisoners to place foreign materials into natural orifices in an effort to gain transfer to an outside healthcare facility. In this article, we present a case series of urethral foreign body insertion of varying burdens and durations

requiring transfer to our facility for surgical management. Endoscopic retrieval was the initial management in each case; one case required conversion to open cystotomy for complete removal due the orientation, amount of inserted foreign body, and erosion into the proximal urethral and bladder urothelium.

Key Words: urethra, foreign body, endoscopy, prison, incarceration, secondary gain

Introduction

Self-insertion of urethral foreign body for secondary gain in the prison population is a rarely described phenomenon that can present a surgical challenge to the urologist. In hostile prison environments, prisoners can become desperate in an effort to avoid violence and assault, and in an effort to gain transfer to a healthcare facility, may attempt to swallow or place foreign body into natural orifices such as the urethra. The incarcerated have an understanding that foreign body concealed in natural orifices can easily exceed the correctional facilities' medical and surgical capabilities; prisoners utilize this knowledge to gain a temporary transfer out of prison. To the authors' knowledge, this case series is the second report of urethral foreign body insertion in the incarcerated population in an effort to garner outside medical attention.¹

Case report

Patient A was transferred to the emergency department in acute urinary retention with blood per urethra and bilateral flank pain. Upon history, the patient confirmed the insertion of three ink pen refills into his urethra 5 months ago and an additional three refills the week

prior to his presentation. He reported a strong desire for transfer after multiple cross-cultural altercations over the prior month. Abdominal and pelvic roentgenograms were obtained in the emergency department and revealed multiple radioopaque foreign body in the bladder and proximal urethra and admission serum creatinine was 3.2 mg/dL. The patient was taken immediately to the operating room after a brief discussion with psychiatric medicine. Endoscopic management of the foreign bodies was attempted but due to orientation of the ink refills and erosion into urethral and bladder mucosa, open cystotomy was required for the complete foreign body burden removal, Figure 1. The patient was discharged to the correctional facility on postoperative day number two with an indwelling Foley catheter; the patient successfully voided on postoperative day five at the correctional facility.

The second case is Patient A returning to the emergency department 6 months after his initial intervention with five pen-ink refills per urethra that were all placed within the previous week. The patient was spontaneously voiding blood tinged urine and denied any other symptoms. Given the short duration of placement and no prolonged interval between pen refill insertions, erosion was not an issue. Psychiatric medicine was again notified that the patient had returned, and the patient was taken immediately to the operating room. This case was managed endoscopically with a 22-Fr cystoscope and a 30 degree lens utilizing cystoscopic graspers and a Segura basket. The patient was returned to the facility later that evening without Foley catheter.

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Figure 1. A total of six ink pen refills were retrieved from Patient A's lower urinary tract. Note the V-shaped bend required to advance the objects proximally.

The third case is Patient B who was transferred to the emergency department after ingesting cafeteria utensils and inserting several objects per urethra 3 days prior to transfer after obtaining the idea from Patient A in the prison recreation yard. He reported several episodes of assault and desired transfer out of the correctional facility for nausea, hematuria and stranguria. Three "spork" utensils were ingested and three ink pen refills and two pieces of milk carton cardboard were inserted per urethra; all objects were endoscopically retrieved utilizing a cystoscopic grasper and a Segura basket. Gastroenterology gastroscopically retrieved the entire alimentary foreign body burden, Figure 2.



Figure 2. Patient B's pelvicroentgenogram demonstrating a lower urinary tract foreign body burden.

Discussion

The insertion of foreign body into the lower urinary tract for secondary gain (i.e., transfer to a healthcare facility) is a rare phenomenon that can be an unexpected surgical challenge with psychiatric implications. These patients can present with a wide range of signs; the most popular include urinary retention and gross hematuria, but systemic manifestations such as fevers, uremia, or sepsis can occur; the most effective management for removal is determined by the length of time to presentation from insertion, the number and size of the foreign body burden, radiographic orientation and endoscopic mobility of the object.²⁻⁶ In most circumstances, endoscopic management is a reasonable initial intervention with the understanding that conversion to laparoscopic or open surgery can be necessary in cases of larger burdens of prolonged duration; cystotomy is not uncommonly required for complete object removal particularly when an endoscopic approach cannot completely clear the foreign body burden or visualization of the entire lower urinary tract is compromised.²

The communication of successful transfers out of correctional facilities leading another prisoner to emulate this act is consistent with the socially contagious nature of urethral foreign body insertion as described in the index case of urethral foreign bodies in the incarcerated population.¹ News of successful furloughs from incarceration travels quickly, and it appears a select few will risk temporary or even permanent consequences to the genitalia or the lower urinary tract for a break from a hostile prison environment. These patients need not only prompt surgical intervention, but also a psychiatric medicine evaluation and long term treatment; changes to prisoner privileges and restricting access to repeatedly inserted foreign bodies should be considered. □

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