Introduction

A 76-year-old gentleman presented with fever with voiding and storage lower urinary tract symptoms. He was a known case of diabetes mellitus and ischemic heart disease. He had a history of recurrent urinary tract infection (UTI). On local examination, he had left epididymoorchitis. Blood investigations showed leukocytosis (20,000/cu.mm) and raised serum creatinine levels (3.0 mg/dL). Urine routine microscopy showed loaded pus cells. Urine culture was positive and the patient was started on 3rd generation cephalosporins. Non-contrast computed tomography scan findings were: Left solitary functioning kidney with hydronephrosis, right poor functioning kidney, and trabeculated small capacity bladder. Under antibiotic cover, the patient was planned for cytoscopy and left Double J (DJ) stenting.

During cytourethroscopy, the patient had a short segment bulbar urethral stricture. This was managed with optical internal urethrotomy (1). Cystoscopy showed multiple prostatic urethra and bladder synechiae, bladder diverticula, and small bladder capacity (Images 1, 2). A stalagnate like pillar, classical of vesical synechiae, was identified (Image 3) (2). With difficulty, the left ureteric orifice was identified at 1-o’clock. Retrograde pyelography showed an upper ureteric kink and DJ stenting was difficult. The patient improved clinically and is under follow-up. Till date, retained suture material due to urological surgery has been identified as the cause of synechiae. However, our patient didn’t have a history of surgery. No foreign material was identified during cystoscopy. Hence, we postulate that recurrent UTI and bladder outlet obstruction (stricture urethra) contributed to the development of synechiae. Laser incision of synechiae is recommended as the treatment.

Keywords: Urology, synechiae, urinary tract infection
(after ureteric reimplantation) and bladder synechiae (after ureteroneocystostomy during cadaveric renal transplantation) have been reported (1). Two cases of bladder synechiae (after anti-incontinence surgery in females) have been reported (2). We report a rare case of prostatic urethral and vesical synechiae secondary to recurrent UTI and bladder outlet obstruction (BOO). This was incidentally diagnosed on cystoscopy. To date, urological synechiae have been identified after the history of any urological surgery. Retained foreign body-like suture material can cause inflammation and synechia formation. The index patient did not have a history of any surgery to cause synechiae. Also, we could not identify any foreign body that caused urological synechiae. Hence, we postulate that recurrent UTI and BOO (Stricture Urethra) caused synechiae. When bacteria invade the bladder mucosal wall, an inflammatory reaction called cystitis are produced (3). Recurrent episodes of UTI can contribute to the development of urethral and vesical synechiae. The stalagnate like pillar formation would have drifted the ureteric orifice to 1-o’clock position. Synechiae are diagnosed on cystoscopy and cannot be diagnosed preoperatively on radiological imaging. Hence, knowledge of such a rare finding can avoid intraoperative surprises. These synechiae can be managed with a Holmium laser incision. Management of BOO and UTI is integral to the management of urological synechiae.

**Ethics**

**Informed Consent:** Informed consent was obtained from the patient.

**Peer-review:** Externally peer-reviewed.

**Authorship Contributions**


**Conflict of Interest:** No conflict of interest was declared by the authors.

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**References**