Introduction and objectives

- Urethral diverticulum in females is uncommon and is probably due to blocked or infected mid/distal peri-urethral glands.
- The diagnosis is easily missed. A classical triad of symptoms; dysuria, dyspaerunia and dribble, is described but often there are numerous symptoms.
- There are only 2 UK case series in the literature with small numbers of patients (n=18 and n=30). Urodynamic characteristics are particularly poorly defined.
- Therefore our aim was to review our three year experience in the management of urethral diverticulae with a focus on voiding dynamics.

Materials and methods

- Retrospective cohort study for 18 consecutive patients in a single surgeon series 2008-2013.
- All urodynamic traces reviewed.
- Blavis-Groutz nomogram used to classify outflow obstruction.
- Surgical excision consisted of; Inverted U incision, excision of the diverticulum, repair of the urethral defect, Martius fat pad interposition (n=12) and a urethral catheter for three weeks.
- Median age 39 (21-50 range) and mean follow up 8.6 months.

Results

- 1/3 of patients were misdiagnosed and often referred from other specialties. 2 patient presented with acute retention due to infected UD.
- 75% were in mid/distal urethra and size ranged from 10-33mm.

Conclusions

- Bladder outflow obstruction (BOO) in women is uncommon. To the best of our knowledge this is the first study demonstrating the obstructive nature of Urethral Diverticulum.
- No patients presented with the classical triad. The diagnosis can be easily missed and clinical suspicion is required when assessing patients.
- Our results are in keeping with the current literature suggesting that where there is an expertise in female and reconstructive surgery the learning curve for urethral diverticulectomy is acceptable.
- Further work is warranted to assess if high voiding pressures are reduced post diverticulectomy and correlate this to lower urinary tract symptoms.

References