Case Report

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Giant Vesical Calculus Presenting as Vesicocutaneous Fistula

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Key Words

Vesical calculus
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Abstract

A rare case of giant vesical calculus weighing 1,365 g and presenting as vesicocutaneous fistula is described.

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Introduction

The incidence of vesical calculi is decreasing in the West, but the situation is not much altered in developing countries. The size of vesical calculi varies, and a giant stone weighing more than 1,000 g has been described in the literature [1].

Case Report

A 30-year-old male patient presented with cutaneous vesical fistula and suprapubic mass for the last 3 months. He was passing about 100-200 ml of urine/24 h from below and the major urine output was from the fistula situated midway between umbilicus and sym-physis pubica (fig. 1). There were no symptoms of lower outflow obstruction, but constipation was significant and his food intake has markedly decreased resulting in weight loss. He had a past history of open cystolithotomy 5 years before. On clinical examination, a vesicocutaneous fistula was noted, and the suprapubic lump palpated was a giant vesical calculus which has eroded the layers of the anterior abdominal wall. Rectal examination revealed a nearly obstructed rectum by the calculus. Hemoglobin was 9 g, and ESR was

raised. Urine microscopy showed plenty of WBCs and culture yielded growth of *Pseudomonas*.

X-Ray of the kidney, ureter and bladder showed a giant vesical calculus (fig. 2).

Ultrasonography detected changes of mild hydronephrosis on the right side, and intravenous urogram showed good excretion on both sides (fig. 3). Ascending urethrogram was normal. He underwent excision of the fistula and suprapubic cystolithotomy. Because it was the second exploration, adhesions were plenty with pelvic wall and bowels. The stone was easily crushed by chisel and hammer and removed piecemeal. It was a mixed stone containing calcium, phosphate, oxalate and uric acid. The stone weighed 1,365 g (fig. 4). Postoperative progress was uneventful.

Discussion

Giant vesical calculi have been the story of the past in the western literature, but in developing countries cases are still encountered which baffle the urologist. The surprising thing in this case has been the occurrence of a fistula in the absence of lower outflow obstruction. Even upper tracts were not dilated. Probably with erosion of the

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Fig. 1. Clinical photograph showing vesi-cocutaneous fistula.
Fig. 2. Plan X-ray of the kidney, ureter and bladder showing a giant vesical calculus.
Fig. 3. Intravenous urogram showing stretched ureters and no filling of the bladder.

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anterior abdominal wall and the resultant fistula, obstruction has not occurred. The bursting of the anterior abdominal wall and bladder must have related to previous surgery done 5 years ago. Absence of lower tract symptoms and hematuria were significant.

Here, modern management of urolithiasis has hardly anything to do, and it was advisable to go for breaking the stone rather than removing en masse. Because the second exploration has resulted in severe adhesion, bladder damage was minimized with the breaking up of the stone.

The patient had probably a milder degree of obstruction to the lower intestinal tract as constipation was significant which has improved after removal of the stone. The giant stone weighing 1,365 g presenting as vesicocutaneous fistula is a rare event.

Fig 4. Photograph showing the broken up calculus.

Reference

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