Ultrasonographic and Retrograde Urethrographic Assessment of Aetiological Factors of Bladder Outlet Obstruction in Adult Males in Port Harcourt, Nigeria

Awajimijan Nathaniel Mbaba1, Michael Promise Ogolodom2*, Rufus Abam1, Alazigha Nengi2, Hyacienth Uche Chiegwu3, Abdulfatai Kolawole Bakre4 and Robert Oziegbe Akhigbe3

1Department of Radiology, Rivers State University Teaching Hospital, Port Harcourt Rivers State, Nigeria
2Rivers State Hospitals Management Board, Port Harcourt Nigeria
3Department of Radiography and Radiological Sciences, Faculty of Health Sciences and Technology, Nnamdi Azikiwe University, Nnewi Campus, Awka Anambra State, Nigeria
4Esteem Diagnostics Medical Services Ltd, Lagos State, Nigeria

*Corresponding author: Michael Promise Ogolodom, Rivers State Hospitals Management Board, Port Harcourt Nigeria, Tel: +234803997393; E-mail: mpos2007@yahoo.com

Received date: 09 September 2019; Accepted date: 20 September 2019; Published date: 27 September 2019


Abstract

Background: Bladder Outlet Obstruction (BOO) imposes a significant burden on health and quality of life of the affected individuals globally. The incidence and prevalence of BOO in adult males increase as the population ages. With advanced BOO serious complications are common including urinary retention, renal failure and premature death. A considerable number of aetiological factors are responsible for BOO in males, some of which depend on the age and others vary from place to place. Understanding and categorizing these factors are crucial for diagnosis and management.

Aims and Objectives: This study was designed to assess the aetiological factors of Bladder Outlet Obstruction (BOO) using ultrasonography and retrograde urethrography, in adult males in Port Harcourt Rivers State, Nigeria.

Materials and Method: This was a prospective study, which involved ultrasonography and retrograde urethrography investigations of BOO using General Electric Ultrasound Logic P6 with 3.5 MHz transducer and Itaïray static X-ray machine respectively. Two hundred and sixteen adult males with obstructive urinary symptoms referred to the Radiology Department of Rivers State University Teaching Hospital were included in this study. Ethical clearance was obtained from the Institutional Ethical and Research Review Board. Patients’ consent was properly sought and all information obtained was treated with high level of confidentiality. Descriptive statistic was done using SPSS version 21.

Results: Out of 216 patients evaluated, Prostatic Enlargement was highest 64% (n=138) and the least were adult posterior urethral valve and urethral diverticulum, which is 0.5% (n=1) respectively. Age group 60-69 years were highest 38.43% (n=83) and the least were within age group 20-29 years age.

Conclusion: The most common causes of BOO pathology in this study was prostatic enlargement. Majority of the cases were within fifth and seventh decades of age.

Keywords: Adult males; Bladder outlet obstruction; Retrograde urethrography; Ultrasonography

Introduction

Bladder outlet obstruction (BOO) is a urological condition where the urine flow from the urinary bladder through the urethra is impeded. The hallmark of bladder outlet obstruction is urinary retention which may be acute or chronic. Urinary retention is a common urological problem seen worldwide, predominantly in the elderly [1,2]. The incidence increases with age so that a man in his 70s has 10% chances and a man in his 80s has more than 30% chances of having episode of acute urinary retention [1,2].

The burden of BOO is high in Africa with attendant poor quality of life. World Health Organization (WHO) in 2011 presaged that by 2018 about 2.3 billion individuals worldwide would be affected by Lower Urinary Tract Symptoms (LUTS) and 1.1 billion men would have symptoms of bladder outlet obstruction (BOO) [3,4]. It was further postulated that the greatest burden of BOO associated LUTS would be in the developing regions of Africa with a projected increase of 31.1% between 2008 and 2018 [3,4].

A considerable number of aetiologies are responsible for bladder outlet obstruction in men and these may include organic obstructions from benign prostatic hyperplasia (BPH) (Figure 1), carcinoma of the prostate, bladder cancer, urethral stricture, iatrogenic causes such as intraurethral
injection of bulky agents in the treatment of intrinsic sphincter deficiency (ISD) and also psychogenic causes [5,6]. Other aetiopathological causes include bladder calculi, urethral calculi, cystocele, posterior urethral valves, urethral spasms, urethral diverticulum and neurogenic bladder.

The issue of how to accurately evaluate BOO in men with LUTS has been debated for decades because of its complex aetiopathological factors [7-9]. A number of studies have suggested that a considerable proportion of men presenting with suspected outlet obstruction are not obstructed as determined by pressure flow criteria [10]. Thus when considering management of men with LUTS suggestive of BOO, it is important to take into account the aetiopathological entities of BOO.

BOO induced LUTS may be predominantly obstructive, irritative, or often a combination of both. Typically obstructive symptoms include hesitancy, incomplete bladder emptying, poor urinary stream and post voidal urinary dribbling. Irritative complaints include urinary urgency, frequency of urination, occasional dysuria, and nocturia. Obstruction can be functional due to Detrusor-Sphincter Dyssnergy (DSD). BOO may also occur in the complete absence of symptoms and can manifest for the first time as urinary retention or decompensation of the upper urinary tracts [11].

Increased outlet resistance as seen in patients with bladder outlet obstruction is the commonest mechanism of urinary retention. It may result in bladder hypertrophy, dilatation, trabeculations, sacculations and diverticulations. Bladder changes may also result in functional failure of ureterortrigonal complex, resulting in vesicoureteric reflux, with the resultant back pressure on the ureters and collecting system leading to the development of hydroureteric and hydronephrosis. With time, persistently elevated intrarenal pressure may lead to tubular epithelial atrophy and eventual nephron loss. The functional consequence is impaired glomerular function and eventual chronic renal failure [11]. Long term or high grade bladder outlet obstruction can permanently damage all parts of the urinary system. The incidence and economic burden is not known in our setting, yet, it is a common urologic problem [3,12,13].

Early diagnosis of the cause and treatment of BOO is necessary to avert its long term complications. Despite the advances in cross sectional imaging such as Computed Tomography (CT) and Magnetic Resonance Imaging (MRI), Ultrasonography remains a first line modality for imaging the pelvic structures such as the urinary bladder and its base. Ultrasound is the most commonly used diagnostic imaging modality, accounting for approximately 25% of all imaging examinations performed worldwide at the beginning of the 21st century [14]. The success of ultrasound may be attributed to a number of attractive characteristics, including the relatively low cost and portability of an ultrasound scanner, the non-ionizing nature of ultrasound waves, the ability to produce real-time images of bloodflow and moving structures such as the beating heart, and the intrinsic contrast among soft tissue structures that is achieved without the need for an injected contrast agent [14]. There are many imaging tools for the assessment of the bladder outflow tract (Urethra) but retrograde urethrography is considered first in the imaging armamentarium.

Retrograde urethrography (RUG) and voiding cystourethrography (VCUG) are the modalities of choice for imaging the urethra. Retrograde urethrography a time-tested imaging technique remains the best initial investigation for urethral and periurethral imaging in men and is indicated in the evaluation of urethral injuries, strictures (Figure 2), and fistulas [15,16]. It facilitates proper definition of the location, length, number, and degree of strictures as well as the periurethral abnormality. The sensitivity of RUG in the evaluation of urethral strictures is about 75–100% with specificities in the range of 72–97% [17]. Retrograde urethrography is a straightforward easy to perform, readily available, reproducible and cost-effective examination that can detect clinically relevant strictures involving the anterior urethra as well as those with extension into the membranous urethra [18-20]. RUG may be combined with Voiding Cystourethrography (VCUG) for the evaluation of posterior urethra.

A considerable number of aetiopathological factors are responsible for BOO in males, some of which depend on the age and others vary from place to place. Understanding and categorizing these factors are crucial for Clinicians especially surgeons in resource limited environment to be conversant with the pattern of bladder outlet obstruction in their setting so as to rationally approach the differential diagnosis as well as offer appropriate management. To the best of our knowledge, there is paucity of studies on BOO in our setting. This study was designed to assess the aetiopathological factors of Bladder Outlet Obstruction (BOO) using ultrasonography and retrograde urethrography, in adult males in Port Harcourt Rivers State, Nigeria.

**Figure 1** Gray scale ultrasound image of the bladder in sagittal and transverse views showing an enlarged prostate gland creating a bulge in the bladder base, representing prostatic enlargement.
A purposive sampling technique was used for selection of 216 adult male patients aged between 20 to 80 years referred from Urology Department and other peripheral hospitals to the Department of Radiology for investigation on account of obstructive urinary symptoms based on the inclusion and exclusion criteria set for this study.

**Inclusion Criteria and Ethical Considerations**

All adult males with age range 20-80 years that presented with symptoms of BOO were included in this study, while all those that have acute urethritis, diabetic conditions and paraplegic were excluded, including those that do not meet the aforementioned inclusion criteria.

Prior to this study, ethical approval was obtained from the Ethical Review Committee (ERC) of Braithwaite Memorial Specialist Hospital, Port Harcourt, and Rivers State, Nigeria. Informed consent was also taken from all the patients who participated in the study they were assured of the confidentiality of the data and in order to protect their rights, the names of the participants were not required. They were also informed that they reserve the right to withdraw from the study at any time if they so decide.

**Methodology**

All procedures for the investigations were adequately explained to the participants, and then the age and indication for the study were recorded. The ultrasound investigations were performed using standard protocols and techniques for transpubic scans using Real time GE Logic P6 PRO gray scale, 3D machine fitted with a 3.5 MHz sector transducer. All patients had transpubic ultrasound scan to identify the anatomic causes of BOO and where no obvious cause was found but post-voidal residual urine volume was significant and retrograde cystourethrogram was done. The volume of residual urine considered to be significant in this study was 50 ml, which is obtainable in other literature [21,22]. Standard protocols and techniques were adopted for Retrograde Cystourethrogram (RUG) investigation for the evaluation of the urethra in patient with suspicious urethral pathology and there was significant post-voidal residual urine volume on ultrasound scan.

**Data Collection and Analysis**

Data such as age and radiological findings were collected using a structured proforma. Descriptive statistics (mean, standard deviation, frequency table and percentage) was used for data analysis using statistical package for social sciences (SPSS) version 21 (SPSS Inc Chicago., ILL USA).

**Results**

Out of 216 adult male patients with mean age of $62.3 ± 11.23$ years (range 20-79 years) included in this study, 64% (n=138) had prostatic enlargement as highest, followed by
urethral stricture 17.12% (n=37) and the least were adult posterior urethral valve (APUV) and diverticulum, which is 0.5% (n=1) each (Table 1).

Table 1 Summary of findings on ultrasound and retrograde urethrogram.

<table>
<thead>
<tr>
<th>Disease Condition</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostatic enlargement</td>
<td>138</td>
<td>63.9</td>
</tr>
<tr>
<td>Bladder calculi</td>
<td>10</td>
<td>4.6</td>
</tr>
<tr>
<td>Bladder tumor</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>Urethral structure</td>
<td>37</td>
<td>17.1</td>
</tr>
<tr>
<td>APUV</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Urethral diverticulum</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Normal RUG</td>
<td>25</td>
<td>11.6</td>
</tr>
<tr>
<td>Total</td>
<td>216</td>
<td>100</td>
</tr>
</tbody>
</table>

Of the total subjects studied, 39.35% (n=83) were within age group 60-69 years of age as highest, followed by age group 70-79 years 29.17% (n=65) and the least were within age group 20-29 years, which is 1.85% (n=4) (Table 2). Out of 83 subjects within age group 60-69 years, 72.3% (n=60) had prostatic enlargement as highest, followed by urethral stricture 8.43% (n=7) and none had APUV as causes of BOO in our study (Table 2).

Table 2 This table illustrates the distribution of aetiological factors of BOO with age.

<table>
<thead>
<tr>
<th>Disease Conditions</th>
<th>Age</th>
<th>Prostatic Enlargement</th>
<th>Bladder Calculi</th>
<th>Bladder Tumor</th>
<th>Urethral Stricture</th>
<th>APUV</th>
<th>Urethral Diverticulum</th>
<th>Normal RUG</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20-29</td>
<td>1</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td>4</td>
<td>1.85%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30-39</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td>2.78%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>40-49</td>
<td>6</td>
<td>1</td>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td>17</td>
<td>7.87%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50-59</td>
<td>26</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td></td>
<td></td>
<td>3</td>
<td>41</td>
<td>18.98%</td>
</tr>
<tr>
<td></td>
<td>60-69</td>
<td>60</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td></td>
<td>8</td>
<td>83</td>
<td>39.35%</td>
</tr>
<tr>
<td></td>
<td>70-79</td>
<td>46</td>
<td>3</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td>14</td>
<td>65</td>
<td>29.17%</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>10</td>
<td>4</td>
<td>37</td>
<td>1</td>
<td>1</td>
<td></td>
<td>25</td>
<td>216</td>
<td>100</td>
</tr>
</tbody>
</table>

Discussion

In this study, the most common cause of BOO in adult men is enlargement of the Prostate, which is also known as Benign Prostatic Hyperplasia (BPH). This corroborates the findings from other parts of Nigeria and the world [11,23-28]. It is a highly prevalent disease of older men and is the result of unregulated neoplastic growth of the prostate gland. Prostate size taken as significant in this study is 40 cm³. This is in keeping with findings of previous studies conducted by Elterman et al. [29], Rosier et al. [30] and Rosier et al. [31], which documented that men with prostate volumes >40 cm³ have a 70% chance of being diagnosed with BOO. Prostate volume as a predictor of BOO in men with glands <40 cm³ is not helpful [28]. Also in this study, urethral stricture as an aetiological cause of BOO accounted for 17.12%. There is currently progressive increase in the incidence of BOO due to urethral strictures. This was attributed to the increased trauma related urethral strictures [32], number of permanent catheter bearers, the surge of sexually transmitted disease (STDs) incidence, and misuse of transurethral diagnostic or therapeutic instrumentation [18,33-35].

In our study, majority of the subjects were within the sixth and seventh decades of ages, which accounted for 68.52%. The age of the patient found with significant prostate size causing BOO ranges from 40 years and above. This is similar to the study conducted by Briganti et al. [36], which also noted that the incidence of BPH as well as the presence of bothersome lower urinary tract symptoms (LUTS) increase with age and these conditions are highly prevalent as early as beyond the fourth decade. In this study, urethral strictures as a cause of BOO was found highest within age groups 40-49 and 50-59 years. This is in similar with the finding of a study conducted by Ahidjo et al. [18], which also reported urethral...
stricture as a cause of BOO to be more common among males within the age group 40-45 years.

In this study, adult posterior urethral valve is one of the least causes of BOO, which accounted for only 0.5% and it was noted in a patient within age group 30-39 years. Although, Young et al. [37], reported that exact age of presentation is not known and varies greatly. Posterior Urethral valve is a rare cause of BOO in adults and it has been estimated that it accounts for 10% of PUV cases. Posterior Urethral valves are the commonest cause of urinary obstruction in neonates, but when detrusor contractions overcome obstruction it may remain silent until later life [38,39]. Recurrent UTI and obstructive uropathy are sequelae of adult posterior urethral valve. Cases of urethral diverticulum are rare in males [40-42]. Most urethral diverticuli (90%) are acquired while less than 10% are truly congenital in origin [42]. Urethral Diverticulum was seen in 1 patient accounting for 0.5% in this study.

Conclusion

Bladder Outlet Obstruction is multi-aetiological and prostatic enlargement tops the list of pathologies causing BOO in adult male patients, followed by urethral structure. The aetiologies of BOO varies with age as shown in this study; while benign prostatic enlargement was commonly found in elderly patients and urethral structure was predominant in younger adults.

Recommendations

Transpubic Ultrasonography and Retrograde urethrography are recommended for the initial investigation of adult males presenting with symptoms of bladder outlet obstruction. It is recommended that various strategies for the prevention of the causes of BOO should be formulated especially for those common causes that could be easily prevented. Considering the magnitude of BOO in the society with its resultant complications, further studies may be required to document its incidence and burden nationwide.

References