Nigerian Journal of Paediatrics 1996; 23:(3) 67-9

Solitary Pendunculated Polyp of the Posterior Urethra in a Child

OB Shittu* J Lawani+

Summary

Shittu OB, Lawani J. Solitary Pendunculated Polyp of the Posterior Urethra in a Child. *Nigerian Journal of Paediatrics* **1996; 23 : 67.** A case of solitary pedunculated polyp of the posterior urethra in a five-year old child is reported. This to our knowledge, is the first to be reported in the Nigerian literature. The symptomatology and clinical course are similar to those of posterior urethral valves and urethrocystoscopy is necessary to distinguish one from the other. The polyp is best ablated endoscopically; however, where the requisite expertise or appropriate equipment for a safe endoscopic resection is not available, the lesion can be excised transvesically.

Introduction

SOLITARY pedunculated polyp of the posterior urethra is rare.[1] Polyps can be asymptomatic, but they can also produce symptoms of urinary outflow obstruction which mimic those of posterior urethral valves. In this communication, we present a case of a solitary pedunculated polyp of the posterior urethra treated recently in our unit and which to our knowledge, is the first case reported in a Nigerian child.

University College Hospital, Ibadan.

Urology Unit, Department of Surgery

*Lecturer/Consultant

+Professor

Correspondence: OB Shittu

Case Report

A five-year old child of Hausa/Fulani extraction, presented on April 24, 1994 with difficulty during the voiding of urine, dating from birth. This was characterised by hesitancy, dribbling and prolonged duration to complete voiding. There was also associated intermittent suprapubic discomfort. There was significant failure to thrive and delay in achieving various developmental milestones; for example, sitting was achieved at two years, and walking at three years of age. He had three siblings who were reportedly well. On examination, the child weighed 10kg (55 percent of his expected weight), but was otherwise, well. Abdominal examination did not reveal a palpable bladder and both testes were descended.

The packed cell volume (haematocrit) was 31 percent, the total white blood count was $8.2x10^9/L$, with normal differentials and his haemoglobin genotype was AA. The serum electrolytes and urea were normal as was the serum creatinine which was 0.8mg/100ml. Urine culture yielded a light growth of *Staphylococcus saprophyticus*. A micturating cysto-urethrogram (MCU) showed a dilated prostatic urethra with a smooth filling defect in the centre and bilateral ureteric reflux (Fig). Urethrocystoscopy revealed a solitary polyp, with a peduncle arising from the verumontanum and projecting into the bladder which was minimally trabeculated.

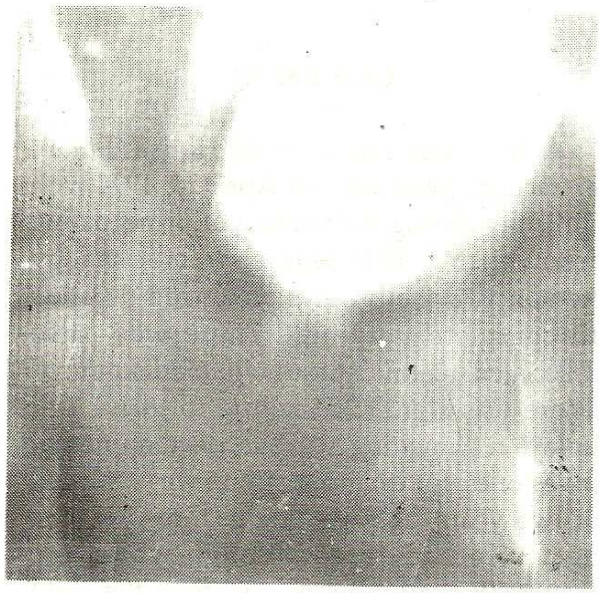

Fig. Micturating cystourethrogram showing dilated posterior urethra and ureteric reflux.

The polyp was resected endoscopically and the immediate post-operative recovery was essentially uneventful. Post-operative follow-up revealed that the child voided with good stream. The child has since been lost to follow-up.

Discussion

Posterior polyp of the urethra is apparently uncommon. William and Abbassian reported four cases and quoted four other cases reported by others, dating to 1938.[1] To our knowledge, this is the first case of a solitary polyp of the posterior urethra to be reported in a Nigerian child. Nwako[2] alluded to the possibility that bladder outflow obstruction may be due to a urethral polyp but did not cite any personal case seen in spite of his extensive experience. Osegbe[3] in Lagos, also reported the treatment of 30 children with bladder outflow obstruction due to posterior urethral valves; in none was the obstruction caused by a urethral polyp. The cause of posterior polyp is unknown, but most cases, as was the present one, are congenital in origin.[2] It has also been suggested that the lesion could be a normal response to long standing urinary infection. [1]

Lower urinary tract obstruction in children can be associated with disturbance of growth, chronic renal failure and high mortality.[4] The polyp could produce posterior urethral dilatation, ureteric reflux and eventually hydronephrosis.[5] Where the diagnosis is not

made early enough, the child may die of uraemia. Our patient presented with poor developmental milestones, failure to thrive, and urinary tract infection which seem to characterise chronic urinary outflow obstruction in children. It would seem appropriate that any child with this combination of clinical features should have the genitourinary system investigated.

A posterior urethral polyp can be adequately treated by an endoscopic resection where the facility and the expertise are available as the morbidity associated with this procedure is minimal.[3] However, where these facilities are not available, the polyp can be excised transvesically.

References

1 William DI, Abbassian A. Solitary pedunculated polyp of the posterior urethra in children. *J Urol* 1966; **96:** 483-6.

2 Nwako FA. A Texbook of Paediatric Surgery in the Tropics. London: Macmllian Press Ltd (Publishers) 1980: 231-6.

3 Osegbe DN. Endoscopic ablation of posterior urethral vales in Nigerian patients. *Nig Med J* 1991; **21:** 131-7.

4 Atwell JD. Posterior urethral valves in the British Isles. A multicentre BAPS Review. *J Paediatr Surg* 1983; **18:** 70-4.

5 Standaas JO. Pedunculated polyps of the posterior urethra in children causing reflux and hydronephrosis. *J Paediatr Surg* 1973; **8:** 517-21.