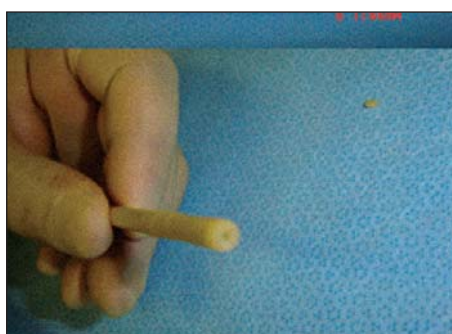
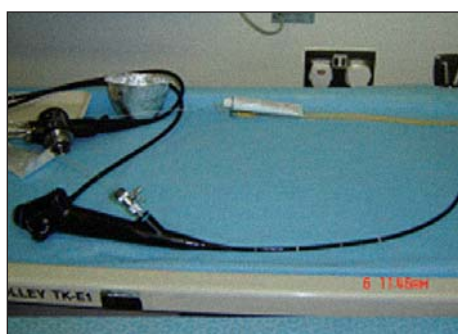
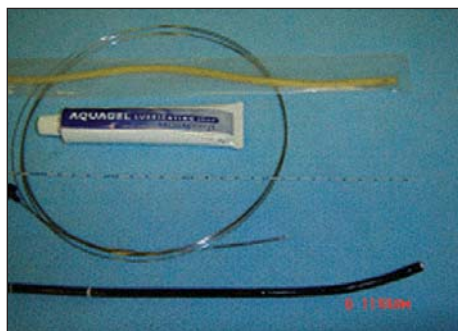


ORIGINAL ARTICLES

Urethral Catheterisation under Direct Vision Using a Flexible Cystoscope and Guide Wire

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Difficult urethral catheterisation is a frequent occurrence for which urological opinion is sought. The common causes are urethral strictures, bladder neck contracture, false passages, benign prostatic hyperplasia and prostatic cancer and massive inguinal hernia with buried penis. Some patients, especially those on anti-coagulant treatment, are vulnerable to a massive bleed in traumatic catheterisation.

We are describing an easy method of inserting urethral catheter under direct vision using a flexible cystoscope (Olympus, CYF-2, 2.2mm channel), a guide wire, (either a oesophageal dilator guide wire (Key Med, 2.5m length, Part no 7028474) or ureteric catheter, (Portex Ureteric Catheter – Blue, 5F, 690mm, Ref. 300/520/050)) and a Foley's catheter (Fr.14 Size). All these are readily available in any hospital.

Using Instillagel, topical anaesthesia and lubrication, we introduced a flexible cystoscope and visualised multiple false passage as well as the true lumen. Under direct vision, we negotiated the flexible cystoscope past the false passages into the bladder, followed by the guide wire through the biopsy channel. Once the guide wire was well advanced into the bladder the flexible cystoscope was withdrawn. We amputated the tip of Foley's catheter just sufficiently to allow intubation over a well lubricated guide wire to show the hole but still tapered and then threaded the catheter over the guide wire. When the Foley's

catheter was inside the bladder we inflated the balloon and withdrew the guide wire. We used a standard Foley's catheter rather than council tipped catheter (1) or a Glidewire (2).

The whole procedure took less than 30 minutes and there was no trauma. All the materials used were taken off the shelf from the endoscopy suite or the ward and should be universally available.

This procedure is simple and avoids suprapubic puncture, which in this case was contraindicated by morbid obesity and lower abdominal wall cellulitis with inability to palpate landmarks reliably.

References

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