Case Reports

RECTOPROSTATIC FISTULA: UNUSUAL PRESENTATION OF A PROSTATIC ABSCESSE


Urology Department. Hospital Universitario Son Dureta. Palma de Mallorca. Spain.

Resumen.- OBJETIVO: Comunicar el caso y la iconografía de una fístula recto-prostática como forma de presentación de un absceso prostático y revisar brevemente la literatura sobre el diagnóstico y tratamiento de esta patología.

MÉTODOS: Varón de 69 años con pluripatología de base que en el contexto de una infección urinaria febril presenta al tacto rectal un orificio en celda prostática apreciándose en TAC y colonoscopia, un absceso prostático fistulizado a recto.

RESULTADOS: Ante el drenaje espontáneo del absceso se optó por el tratamiento conservador con sueroterapia y antibióticos.

CONCLUSIONES: El absceso prostático es una entidad de difícil diagnóstico por su baja prevalencia y su sintomatología inespecífica. Desde la aparición de los antibióticos son cada vez menos los casos que fistulizan o abren espontáneamente a estructuras vecinas como uretra o recto.


INTRODUCTION

Prostatic abscess is a rare process at present. Caused mainly by enterobacterias, it affects mainly immunodepressed or diabetic patients. Since wide spectrum antibiotics appearance, its prevalence and its complications have diminished significantly. We report the case of a patient who presented with rectal bleeding secondary to a rectoprostatic fistula promoted by the spontaneous drainage of a prostatic abscess.

CASE REPORT

69-year-old male with history of alcohol dependence, smoking, hypertension, atrial fibrillation, cerebrovascular disease, dementia and acute lower extremity ischemia that required of aorto-bifemoral by-pass three months before the current episode, using an indwelling catheter and chronically bedridden since then. He was...
readmitted in a hospital of our area of reference ten days after his discharge due to a clinical picture of respiratory infection starting thereafter, treatment with levofloxacin. Blood and urine samples for culture were collected. Blood cultures were negative and urine cultures were positive for *Klebsiella pneumoniae*. During his admission, right epididymis swelling was appreciated, being clinically and sonographically labeled as acute epididymitis. Initial antibiotic treatment was continued. One week later, without previous apparent clinic, he presented an episode of rectal bleeding. In digital rectal examination a flat prostatic fossa with an orifice close to left margin was palpated. Therefore, colonoscopy was requested, where a large size fistula orifice was observed 5 cm far from anus (Figure 1). Ulcer margins were biopsied and pathologist informed of inflammatory changes.

The study was completed with an abdominopelvic scanner appreciating marked inflammatory changes in the rectal low region with wide fistulization to prostatic parenquima where multiple collections of gas were observed. Prostatic urethra was intact (Figure 2). The patient did no present urethral discharge.

Parenteral antibiotic coverage with cephalosporins, aminoglycosides and metronidazole was initiated, being gradually withdrawn because of the good clinical evolution of the patient. Indwelling catheter was kept in order to facilitate urine drainage, rejecting suprapubic catheter placement because of the alteration in coagulation of the patient. Twenty days after patient admittance, and while waiting to move to a nursing home, the patient had cardiac failure leading to sudden death.

**DISCUSSION**

Unlike in the preantibiotic era, prostate abscess is at present a very low prevalence entity with minor morbimortality. A combination of factors, like immunosuppression situations, urethral manipulation, previous urinary infection or bladder outlet obstruction, often predispose to this entity. In the clinical case reported, the patient had a precedent of vascular surgery that needed of an indwelling catheter (1). Radermecker et al. recently presented a case of prostate abscess after cardiovascular surgery. We believe that the above mentioned abscess is related with the factors mentioned previously, instead of the type of surgery.

Most prostatic abscesses are thought to arise from prostatitis due to reflux of infected urine usually by enterobacteria, being *E.coli* the most frequent bacterium isolated (2). A second less frequent origin, is hematogen spread from a distant area, in which case *Staphylococcus aureus* is the most prevalent agent (3). Diagnosis is often difficult because of its unspecific symptomatology. Patients use to present with low urinary tract symptoms, together with perineal pain. Most patients have fever (2) though it is not always present (4). Palpation of the gland is normally painful, being a characteristic, though no pathognomonic, the presence

**FIGURE 1.** Colonoscopy, where fistulizing orifice in rectum can be appreciated.

**FIGURE 2.** CT scan images, where a great quantity of gas in prostatic parenquima together with an air-fluid level can be observed.
of a fluctuating area. This is present in 16-100 % of the patients according to different authors (4-6). Urine cultures can be negative, especially if patient has received antibiotics before (7). For all this, imaging tests are a great help to establish the diagnosis. For this purpose we can use CT scanner (8), NMR (9) and transrectal ultrasound (5).

Treatment can be conservative for single and small size abscesses (2).

Ludwig, in a series of 18 patients, treated 9 patients with single abscesses smaller than 1 cm diameter with suprapubic bladder drainage and empirical antibiotherapy. Three of them needed later surgical drainage because of symptomatology persistence (3). In major size abscesses treatment of choice, together with wide spectrum antibiotherapy, is the ultrasound or CT-guided transrectal drainage of the abscess, which is preferable to the perineal drainage because of its minor morbidity . Some authors support the placement of a drainage in abscess cavity that could be removed after 48-72 hours (10), whereas others do not recommend it (5). Transurethral resection or preferably transurethral incision with a Collings knife are other options to bear in mind if percutaneous drainage is not effective, a situation that can happen particularly in multiloculated abscesses. It is not clear that transurethral resection is associated with higher rate of hematogen spread (5), though there can be a major risk of procedure-related complications (retrograde ejaculation, urethral stenosis or incontinence).

Prostatic abscess presentation with spontaneous fistulization to neighboring organs like urethra (2), ischiorectal area or rectum (4, 11) is nowadays very unusual.

Urine leakage from rectum, pneumaturia and/or fecaluria point out to fistulization to rectum. Spontaneous drainage to another cavity like rectum or urethra often implies symptom resolution. In case of the rectum, urine derivation by means of a suprapubic or transurethral catheter to allow fistula closing is necessary.

CONCLUSIONS

Prostatic abscess and its complications are rare since antibiotic appearance. These facts together with its unspecific symptomatology make it difficult to diagnose, being imaging tests of great utility. Treatment consists in powerful antibiotherapy together with abscess drainage. Spontaneous abscess aperture to a neighboring cavity (rectum or urethra) can lead to symptomatology resolution.

REFERENCES AND RECOMMENDED READINGS

(*of special interest, **of outstanding interest)