Periurethral abscess

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Periurethral abscesses were once common with high morbid ity but are now rare. Clinical presentation is varied but may include fever, dysuria, urethral discharge and swelling of the penis or scrotum. In untreated cases urethral fistulation and occasionally extensive cellulitis or necr otising fasciitis can occur. A penile periurethral abscess arises following a gonococcal or chlamydial infection of one of the glands of Littre. There can be a coexisting urethral stricture. There is usually penile sw elling with tender induration felt on the underside of the penis, which, if left untreated, may discharge externally , often leaving a fistula. Diagnosis can be helped by ultrasound of the urethra. Treatment should include both antibiotic treatment, as for urethritis, and surgical drainage into the urethra. A periurethral abscess in relation to the bulbar urethra is even more uncommon. It may be associated with a urethral stricture, urethral trauma or, rarely , a urethral cancer. The infecting organisms are varied and can include both strep tococci and anaerobic organisms. Extravasation of urine is not unusual. There is perineal pain with pyrexia, rigors and tachycardia. Tenderness and swelling rapidly spread from the perineum to the penis and the anterior abdominal wall. Alexis Littre , 1658–1726, surgeon and lecturer in anatomy , Paris, France. - Ultrasound scanning and MRI are useful diagnostic aids and treatment with antibiotics is essential. Collections of pus should be drained and the urine should be diverted by a supra- pubic urinary catheter. A chronic periurethral abscess sometimes results from a - longstanding urethral stricture (Figure 85.26). The multiple loculi of pus should be drained and the stricture treated. Ure - thral fistula occurs either spontaneously or as a result of inci - sion of the abscess.

(c)

Bladder Penis Pus seen in the perineum appears bright on MRI

The commonest cause of a genital ulcer is genital herpes. Other less common causes include syphilis and chancroid. As with all STIs, the possibility of other infections (such as HIV) should always be borne in mind and, where appropriate, tested for. Genital herpes Genital herpes is caused by sexual transmission of the herpes simplex virus (usually HSV-2, occasionally HSV-1). Infection is lifelong with recurrent symptomatic attacks occurring in 50% or more of cases. Pain along the distribution of the sensory nerve, usually the genitofemoral nerve, precedes the eruption by 2 /uni00A0 days and may be particularly severe around the anus. A group of tiny vesicles rapidly erodes to form shallow ulcers, which are painful (Figure 85.27a). The first attack occurs around 4 days after exposure and is typically accompanied by fever, myalgia and inguinal lymphadenopathy . In female patients, the ulcers often spread onto the thighs during the attack. Involvement of the urethra may cause retention of urine, which may persist for up to 14 days if there is radiculitis of the S2 and S3 nerve roots. Diagnosis is made clinically or, when there is

doubt, by either cell culture or polymerase chain reaction (PCR)-based techniques. All primary infections should be treated by oral antiviral agents such as aciclovir (400 /uni00A0 mg three times a day for 7–10 days), valaciclo vir (1 /uni00A0 g orally twice a day for 7–10 days) or famciclovir (250 /uni00A0 mg three times a day for 7–10 days). to a fatal generalised herpes infection in the neonatal period. Caesarean section should be considered in these circum - stances. There is an increased risk of carcinoma of the cervix and annual cytology for life is recommended. Syphilis Syphilitic ulcers are typically painless, rubbery and indurated. Caused by the spirochaete Treponema pallidum , diagnosis was traditionally achieved by dark-field microscopy , but modern serological techniques are nowadays more appropriate. The incidence of syphilis is increasing since the advent of the retro- viral drugs used to treat HIV in the mid-1990s. Treatment is with long-acting penicillin.

(a) (b) Figure 85.27 (a) Genital herpes. (b) Ulcer seen in chancroid. (c) ital warts affecting the prepuce and glans (courtesy of Dr Narendra Patwardhan, dermatologist, Pune, India).

Revision #1
Created 2025-12-31 15:30:58 UTC by Omar Ayman
Updated 2025-12-31 15:30:58 UTC by Omar Ayman