Psychogenic Urinary Retention: A Case Report

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Abstract

A case of unexplained urinary retention is reported. The diagnosis of psychogenic urinary retention was considered after no organic cause was identified subsequent to medical, urological, neurological and gynecological evaluation. This diagnosis was then confirmed by psychiatric consultation. Urinary retention was managed by Foley's catheterization. Psychotherapy, pharmacotherapy, and behavior therapy were also utilized with satisfactory results.

Keywords: Anuria; Psychogenic; Urinary retention

Introduction

Psychogenic retention of urine should be suspected in patient, who is unable to pass urine voluntarily, however without any discomfort and no urge to pass urine. It is a rare condition with minimal information known or reported in the literature. When no organic causes to decrease urine output can be found in patient with significant psychological stress, psychogenic retention of urine should be suspected. Noninvasive diagnostic methods can be done to rule out any organic pathology. Treatment usually consists of supportive psychotherapy and alleviating the trigger causing the condition.

Case Report

A 19-year-old girl with past medical history of asthma, presented to the emergency department with complaint of inability to pass urine for three days. She had history of fever usually during evening associated with cough but no sputum production. She also had shortness of breath usually during night waking her from the sleep, that decreased by salbutamol inhalation. She had similar history of shortness of breath in the past and was admitted in hospital six months before for asthma. She had no prior history of trauma.

The patient appeared relaxed, oriented to time, place, and person. The physical findings were normal except for occasional wheeze. The abdominal examination was normal and the bladder was not palpable. The neurologic exam was normal, including normal rectal tone, reflexes and sensation. Laboratory tests included a complete blood count and renal function test, which were normal. Ultrasonography of the abdomen and pelvis was done, revealing a small left adnexal cyst of 38 × 34 mm. The kidney and bladder were normal.

The patient was admitted for observation, encouraging oral intake with close monitoring of intake and output. Despite an oral intake of two liters there was no urine output on the first day of admission. The patient was started on intravenous fluids with diuretics; the patient had slight abdominal discomfort, however, the patient continued to have no urine output. Foley’s catheterization was done which yielded 700 ml of urine.

Due to the patient’s recent emotional stresses, bereavement, relationship failure, depressed mood and suicidal ideation, psychiatry was consulted. The patient described she had been having low mood and lack of energy from three years. Her parents would return home under influence of alcohol and fight almost every day. She was verbally abused by her father multiple times. She was denied dinner several times by her mother. She shared her feelings to her closest friend, but she committed suicide a year ago. She was in relationship with a class mate but that did not last long. She had persistently low mood, feeling of worthlessness, sleep disturbances, inability to focus and multiple suicidal ideations since then. The patient was diagnosed with depression and started on selective serotonin reuptake inhibitor (SSRI). Further history revealed prior sexual contact and vaginal discharge, so gynecology was also consulted. The gynecologist diagnosed the patient with cervicitis. Cultures and antibody test (IgG and IgM) for Herpes Simplex Virus were negative. Urinalysis and culture were also negative. Opinion from Nephrologist was taken who suggested that the patient did not have any organic cause. Similarly, opinion from urologist was also taken who suggested cystoscopy. The cystoscopic findings were normal.

Considering the detailed evaluation of the patient, multidisciplinary opinion and necessary investigations, the patient was diagnosed with psychogenic retention of urine. The patient’s Foley catheter was removed on second day of admission following which patient had no urge to pass urine or any urine output for six hours despite three liters of oral intake. Foley’s catheterization was reinserted and 600 ml of urine was collected. The patient was on persistent stress about vaginal discharge and itching. Counseling regarding her disease condition and its prognosis were explained. Patient was started on selective serotonin reuptake inhibitors (SSRI) and Selective serotonin and noradrenaline reuptake inhibitor (SNRI) along with psychotherapy. The Foley catheter was removed on fifth day of admission, patient passed urine normally for three days. She again developed decreased urine output after three days. Patient was started on sodium valproate for mood stabilization. Foley’s catheter was removed on next day, patient complained of decrease urine output but was passing urine normally. Further admission days her mood was better and she had no retention of urine. Patient was discharged on same medications after 21 days of hospital admission.

Discussions

Retention of urine is an secondary uncommon cause to psychological stress. Normally, urinary retention is associated with various etiologies like prolapsed uterus, pelvic mass, uterine fibroid, bladder calculi, fecal impaction, urethral stricture, cystitis and ureteric obstruction. However, in this case, the patient had very little discomfort, normal workup and continued to not have any urine output despite fluids. The patient’s urinary retention only improved following treatment and therapy for depression. Psychogenic retention of urine is caused by change in bladder function in relation to stress, in which the patient has less bladder pressure during periods of stressful events.
Conclusions

Psychogenic retention of urine should be considered when the workup is normal and the patient is under significant stress, however without any discomfort and no urge to pass urine. The onset of retention is usually related to acute psychological stress. Supportive psychotherapy is the primary treatment.

Conflict of Interest

The author has no conflict of interest.

References