ECTOPIC URETER IN THE MALE: CASE REPORT *

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Ectopic ureter in the female, in whom symptoms of incontinence occur by virtue of the fact that the ectopic orifice is situated distal to the vesical sphincter, is not infrequently encountered. In the male, the ectopic orifice lies proximal to the external sphincter, and so attention is only directed to the anomaly if infection ensues.

Two excellent reviews (Young, 1955, and Goldstein and Heller, 1956) have recently appeared in the English and American literature. These show that in only 12 male patients has the clinical diagnosis of an ectopic ureter opening into the genital tract been reported, while a further 32 cases have been found at autopsy.

One other case not mentioned in these reviews is described by Twistington Higgins *et al.* in *Urology of Childhood* (1951). Most of its features are similar to those of our case.

Our case is similar to the majority of those previously published; the ectopic ureter arose from a hypoplastic kidney and opened into the seminal vesicle.

CASE REPORT

The patient, a man aged 37, was first seen in May 1958. He described 3 attacks of difficulty in passing urine, in August 1956, April 1957 and March 1958. During the first of these there had been no associated symptoms, but in the second there had been some burning on micturition. During the third attack, the patient had experienced considerable burning and also increased frequency of micturition and the left testicle had become painful and swollen, but this subsided within a week. On each occasion the urine had been examined by his physician, who found some pus cells. Each attack lasted a few days, the third, about 10 days, being the longest.

On physical examination no abnormality was detected in the chest or abdomen. The blood pressure was normal. A small nodule could be felt in the inferior pole of the left epididymis. On rectal examination the prostate felt normal and the seminal vesicles were not palpable.

Examination of the urine showed an occasional white blood cell, and prostatic massage produced no change in microscopic appearances.

Intravenous pyelography was carried out and demonstrated a normal right kidney and ureter. On the left side, no definite renal outline could be seen and no evidence of the contrast was detected up to 4 hours after injection. The bladder showed an indentation in its left upper quadrant.

At cystoscopy, the right ureteric orifice and right half of the trigone appeared normal. The left half of the bladder base was displaced forwards and medially by a large cystic sausage-shaped swelling, which was flaccid and easily indented by the tip of the cystoscope. This ran from above downwards for about 5 cm., at which point it narrowed and then bulged into the floor of the prostatic urethra as far as the verumontanum. The left ureteric orifice and the opening of the left ejaculator duct could not be identified. With the use of a Stern McCarthy resectoscope carrying an infiltration needle in place of the cutting loop, the cyst was punctured and some thick, tenacious, yellow opalescent fluid withdrawn. This contained some white blood cells, but was sterile and no spermatoza were demonstrated. Through the same needle 30 c.c. of 20% diodone were injected and radiographs were taken immediately and up to 4 hours after injection. This demonstrated a tubular structure in the pelvis (Figs. 1A and 1B) but, although the patient was kept tilted with his head down, no contrast could be made to pass towards the kidney.

Five days later the left vas deferens was punctured in the scrotum and contrast injected. This demonstrated a grossly dilated ampulla but no definite vesicle. Some contrast entered the cyst or bladder (Fig. 2).

The diagnosis of an ectopic ureter entering the genital tract was therefore made and operation advised. A left extra-peritoneal paramedian approach was used. The ureter was found to be greatly dilated below the pelvic brim and showed a well-marked constriction where it was crossed by the superior vesical vessels. Above the brim it was only slightly distended. It arose from an atrophic, cystic kidney lying opposite the 4th lumber vertebra. The kidney was removed.

On being followed down, the greatly distended ureter was

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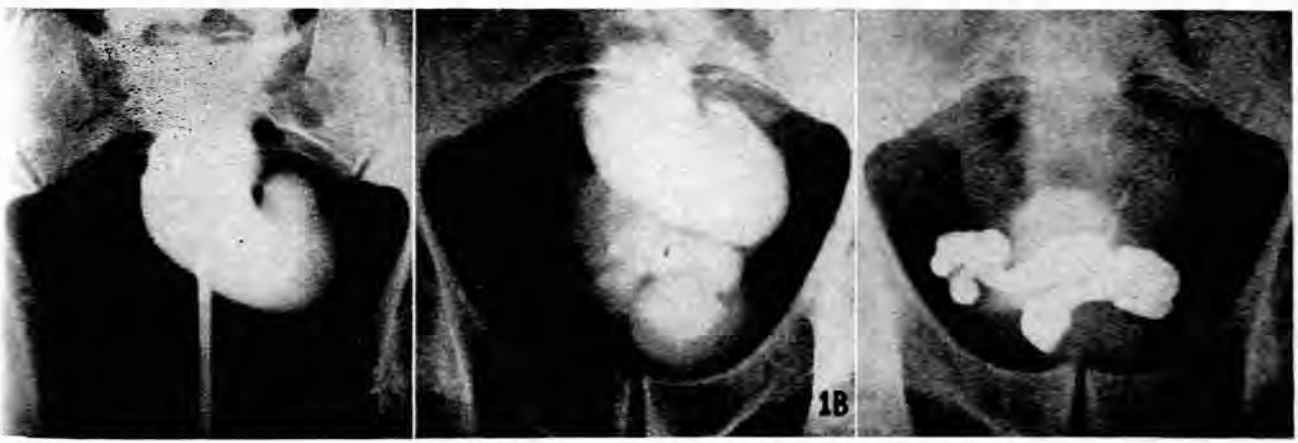

Fig. 1. Cyst outlined by injection of contrast medium during cystoscopy. A: Immediate. B: Four hours after injection.
Fig. 2. Dilated ampulla of vas shown at seminal vesiculography.

found to enter the bladder wall as usual, passing obliquely through the muscle into the submucosal position, and then to re-emerge partly from the wall at the posterior aspect of the neck, where it was joined by the greatly dilated ampulla of the vas. The two continued downwards as a very wide ejaculatory duct, which easily admitted the tip of the little finger. This duct was divided and the ureter and ampulla of the vas were removed.

Post-operative progress was uneventful.

SUMMARY

A case of ectopic ureter is described, opening into the genital tract in the male and presenting characteristic features.

REFERENCES

Azar, H. A. and Somers, S. C. (1958): J. Urol. (Baltimore), **79**, 994.
Ellerker, A. G. (1958): Brit. J. Surg., **45**, 344.
Engel, W. J. (1948): J. Urol. (Baltimore), **60**, 46.
Goldstein, A. F. and Heller, E. (1956): *Ibid.*, **75**, 57.
Hamilton, G. E. and Peyton, A. B. (1950): *Ibid.*, **64**, 731.
Higgins, I. T. T., Williams, D. I. and Nash, D. F. E. (1957): *Urology of Childhood*, p. 260. London: Butterworth.
Meisel, H. J. (1952): J. Urol. (Baltimore), **68**, 579.
O'Malley, J. F. and Bumgarmer, J. E. (1955): *Ibid.*, **73**, 235.
Pasquier, C. M. and Womack, R. K. (1953): *Ibid.*, **70**, 164.
Riba, L. W., Schmidlapp, C. J. and Bosworth, N. L. (1946): *Ibid.*, **56**, 332.
Young, J. N. (1955): Brit. J. Urol., **27**, 57.