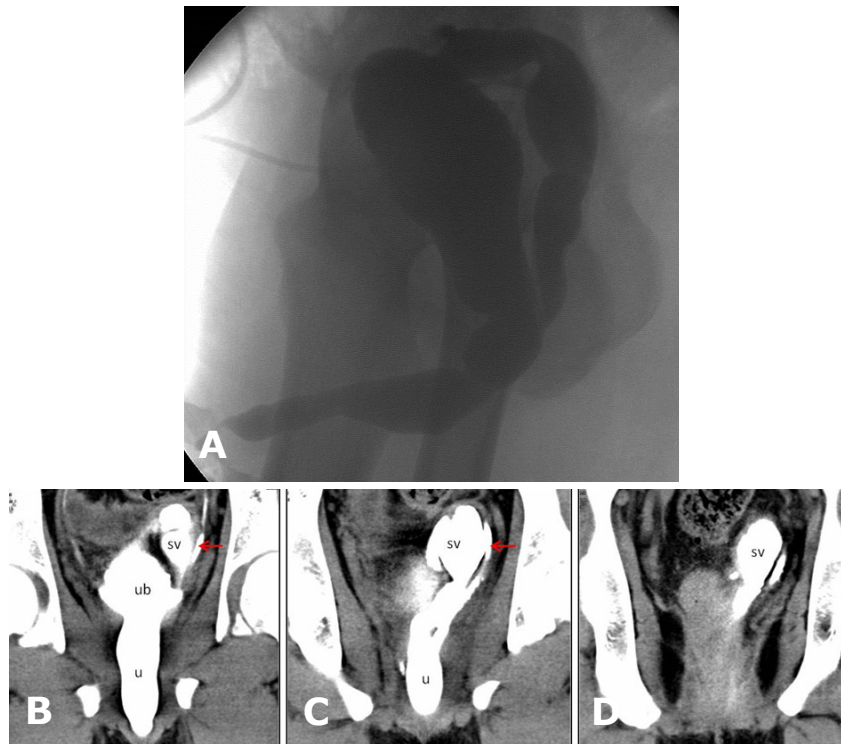


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A 19-year-old boy who had underwent hypospadias repair 10 years ago presented with acute urinary retention. Attempt to insert a continuous bladder drainage fail due to a high urethral stricture. Thus supra-pubic catheter was inserted. On further questioning patient claimed that he had experience symptoms of poor urinary flow with incomplete voiding for a few years. The imaging result showed presence of distal urethral stricture (Figure 1) with other uro-genital tract abnormalities (**Panels A, B, C and D**)

What is the diagnosis?

Answer: refer to page 64

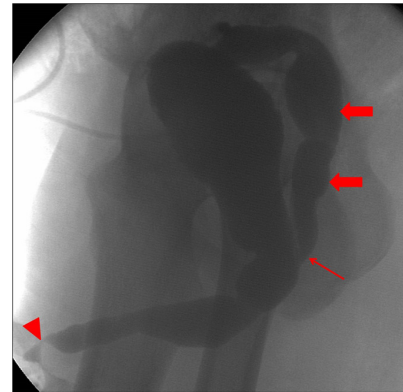
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(Refer to page 44)

Answer: Unilateral seminal vesicle urinary reflux

The **Panel** shows gross dilatation of the urethral secondary to the urethral stricture with resultant seminal reflux. Seminal vesicle dilatation is commonly due urinary reflux and cysts within the gland.¹ These condition is commonly asymptomatic and incidentally found during imaging. In symptomatic cases, commonly reported symptoms include pelvic pain, ejaculatory pain, dysuria, frequency, haematuria, urinary tract infections, and symptoms of epididymitis or/and prostatitis.^{1,2} It can be congenital or acquired. Congenital cases usually become symptomatic in young adulthood. Accumulation of secretions in the gland due to insufficient drainage causes subsequent distension of the seminal vesicles, leading to enlargement of the seminal vesicle during this period.¹⁻³ Imaging findings may show a cystic pelvic mass with a thick irregular wall to a solid mass and apparent enlargement of the ipsilateral seminal vesicle.⁴ Other findings include a well-defined low-attenuation retrovesicular mass arising from seminal vesicle, cephalic to the prostate gland with associated renal anomalies.

Acquired seminal vesicle reflux are often bilateral and are commonly seen in the older age group. It is frequently preceded by a history of chronic prostatitis or prostate



Panel showing urethral stricture (arrowhead), dilated urethra and reflux into the seminal vesicle (small and large arrows)

surgery. Defect in the ejaculatory duct causes distension of bilateral seminal vesicle. In this present case, the obstruction was in the distal penile urethra (**Panel**). Interestingly, only the left seminal vesicle was involved which may suggest possibility of congenital in origin. Presence of urine reflux into the seminal vesicle on micturating cystourethrogram in this case may suggest high pressure obstruction. Other possible pathophysiology include injury to ejaculatory duct during hypospadias repair leading to absence of a one-way valve at that level.

Surgical excision depends on presence of clinical symptoms and the size of the cyst.² In asymptomatic cases, conservative management is usually adequate especially in acquired type of seminal vesicle cyst.

REFERENCES

- 1:** Coppola V, Vllone G, Verregia D, et al. Cystic dilatation of the seminal vesicles: which diagnostic approach. *Radio Med* 1997; 94:68-75.
- 2:** Cesare S, Stefano C, DeMaria M, et al. Robot-assisted removal of a large seminal vesicle cyst with ipsilateral renal agenesis associated with an ectopic ureter and a müllerian cyst of the vas deferens. *J Uro.* 2008; 71:1226.e5-1226.e7
- 3:** Lagalla R, Zappasodi S, Lo casto A, et al. Ultrasonographic (US) and computed tomographic (CT) features of a cystadenoma of the seminal vesicle are presented. *Abdominal Imaging* 1993; 18:1432-509.
- 4:** Sandeep S, Richard SB, Emily MW, et al. CT and MRI of Congenital Anomalies of the Seminal Vesicles. *AJR* 2007; 189:130-5.