Short report

Acute urinary retention due to sacral myeloradiculitis

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SUMMARY Three cases of acute urinary retention without local urological causes are described. A diagnosis of sacral myeloradiculitis of viral origin appeared more likely than a first episode of multiple sclerosis. The literature is reviewed and a protocol for the investigation of such patients is suggested.

Case reports

Case 1 A 20-year-old female student noticed extreme fatigue, malaise and generalised skin hyperaesthesia for two days. On the third day these symptoms disappeared, but she complained of dysuria for three days followed by acute retention. Catherisation in the casualty department revealed a residual volume of 1500 ml. Clinical and neurological examination was normal. As she was currently at loggerheads with her parents, a psychogenic cause was suggested and she was advised "to jump frequently downstairs in order to activate the bladder". This therapeutic suggestion failed and she was readmitted to hospital with retention (1400 ml). The external urogenital tract was normal, cystoscopy showed no infravesical obstruction, and a voiding cystogram showed only residual urine. Blood and urine analysis were normal. A detailed neurological examination showed no abnormalities. In view of the non specific symptoms suggesting a viral illness, a lumbar puncture was performed which showed a colourless liquor under normal pressure. Laboratory findings are shown in the table. The retention resolved rapidly, and the patient was discharged symptom free on the fifth day. She had remained well for three years. No causative viral agent could be detected.

Case 2 A 31-year-old female school teacher presented with a two day history of malaise and myalgia. She had noticed frequency and dysuria resulting in acute retention. On admission, the external urogenital tract appeared normal. The bladder was large with a residual urine of 1300 ml. Apart from an inconstant sacral hypalgesia (S1–3), neurological examination was normal. Cystoscopy and intravenous urography revealed no abnormalities. At lumbar puncture a pleocytosis was present (see table). Viral cultures were negative but the ECHO 9 complement fixation tests rose from 1/8 (day 2) to 1/128 (day 17), suggesting a sacral myeloradiculitis of viral origin. The retention resolved over three days, and the patient has remained well for 18 months.

Case 3 A 21-year-old housewife complained of dysuria and was treated by her family doctor with sulphonamides. Acute retention developed one week later and she was admitted to hospital. The external urogenital tract was normal. The bladder was enlarged with a residual urine of 1350 ml. Neurological examination was normal apart from a possible decrease in anal sphincter tone. Blood and urine analysis were normal. Cystoscopy and voiding cystourethrogram showed no abnormality apart from residual urine. At lumbar puncture a pleocytosis was again present (see table). Viral studies were negative. The retention resolved rapidly and the patient has been well for 18 months.

Discussion

Acute urinary retention as an isolated sign is rarely of neurological origin: multiple sclerosis, medullary compression or a disc protrusion are well recognised causes. Minor complaints such as transient paraesthesiae can be overlooked leading to extensive urodynamic investigations in search of a local cause. If these investigations are negative, a psychogenic aetiology is often considered particularly in young women who...
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Table CSF findings in three reported cases

<table>
<thead>
<tr>
<th>Patient</th>
<th>Protein</th>
<th>White blood cells/μl</th>
<th>Glucose</th>
<th>Globulins and IgG's</th>
<th>VDRL TPI tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.22g/l</td>
<td>24 lymphocytes</td>
<td>3.2</td>
<td>nil</td>
<td>neg</td>
</tr>
<tr>
<td>2</td>
<td>0.40g/l</td>
<td>48 lymphocytes</td>
<td>3.5</td>
<td>nil</td>
<td>neg</td>
</tr>
<tr>
<td>3a</td>
<td>0.70g/l</td>
<td>141 lymphocytes</td>
<td>3</td>
<td>nil</td>
<td>neg</td>
</tr>
<tr>
<td>(day 1)</td>
<td>0.50g/l</td>
<td>33 lymphocytes</td>
<td>3.2</td>
<td>nil</td>
<td>neg</td>
</tr>
</tbody>
</table>

appear unconcerned with their illness. In these cases exclusion of a neurological cause is often made on clinical examination alone.

All our patients were young women who presented with a viral-like illness culminating in acute retention without a local cause. Neurological signs were minimal but the CSF was abnormal in all cases. A definitive viral agent (ECHO 9) was identified in one case. A first episode of multiple sclerosis cannot be excluded in any of these cases, but with normal CSF immunoglobulin analysis, a symptom free follow-up period of several years, and the absence of other neurological signs, a diagnosis of viral sacral myeloradiculitis seems more likely.


References


