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Case Report

When a wart blocks the way: urethral condyloma presenting as acute urinary retention in pregnancy

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ABSTRACT

Urethral wart (condyloma acuminatum) is a rare cause of acute urinary retention (AUR) in pregnancy. We report a 29-year-old gravida 2 who presented at 32 weeks' gestation with AUR. Examination revealed a 2×1 cm friable, vascular growth just at the urethral meatus obstructing the lumen. There were no associated other sexually transmitted infections nor she had any pelvic pain or foul-smelling discharge and fetal surveillance was reassuring. There was immediate relief in urinary retention following excision under local anaesthesia. Histopathology confirmed condyloma acuminatum with koilocytosis. She subsequently had a spontaneous preterm vaginal delivery of a healthy 2.2 kg female infant, with no repeat episode of urinary retention. This case highlights urethral wart as a rare mechanical cause of bladder outlet obstruction in pregnancy and shows that prompt local excision safely restores voiding without adverse maternal or fetal outcome.

Keywords: Condyloma acuminatum, Urethral wart, Acute urinary retention, Pregnancy, Human papillomavirus, Bladder outlet obstruction

INTRODUCTION

Acute urinary retention (AUR) in pregnancy is uncommon, occurring in roughly 1 in 3000 pregnancies, and is most often attributed to uterine retroversion or incarceration, pelvic masses, neurological causes; severe pain due to acute HSV infection or urethral pathology is rarely considered.[1] Urethral condyloma acuminatum, caused by low-risk human papillomavirus (HPV) types 6 and 11, accounts for under 5% of anogenital warts, and pregnancy-related hyperoestrogenism, mucosal vascularity, and relative immune tolerance can drive rapid enlargement of existing or latent lesions.[2]

We describe a pregnant woman in whom a solitary urethral wart produced acute retention, to draw attention to this rare but readily treatable mechanical cause.

CASE REPORT

A 29-year-old gravida 2 para 1 at 32 weeks' gestation presented with sudden inability to pass urine and progressive lower abdominal discomfort of a few hours' duration. There was no dysuria, haematuria, fever, or recurrent urinary infection, and her antenatal course had otherwise been uneventful. She was afebrile and her vitals were within normal limits. Abdominal examination confirmed a gravid uterus appropriate for dates with a palpable, distended bladder and a normal fetal heart rate. Local examination revealed a reddish, fleshy, approximately 2×1 cm papillomatous mass arising from the urethral mucosa and fully occluding the meatus (Figure 1); it was soft, vascular, and bled slightly on contact, with mild surrounding mucosal congestion. She had never undergone any local examination prior to this nor did she get any cervical smear prior to pregnancy. No other vulvar,

vaginal, or cervical lesions were seen. Urine microscopy and culture were normal, and serology for HIV, syphilis, and hepatitis B was negative. Ultrasonography confirmed satisfactory fetal growth and wellbeing.

After catheter drainage of the bladder and informed consent, the lesion was excised under local anaesthesia, with satisfactory haemostasis (Figure 2). Histopathology confirmed condyloma acuminatum, showing papillary acanthotic epithelium with koilocytosis. A urethral catheter was retained for 48 hours and removed after a trial of clamping and voiding; the patient voided normally thereafter with a negligible post-void residual. She subsequently went into spontaneous preterm labour and delivered a live female baby weighing 2.2 kg. The postpartum course was uneventful.

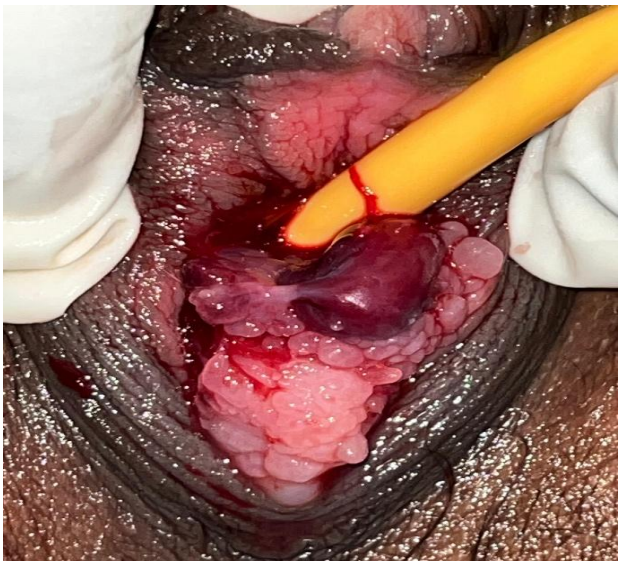

Figure 1: Urethral wart at the meatus before excision.

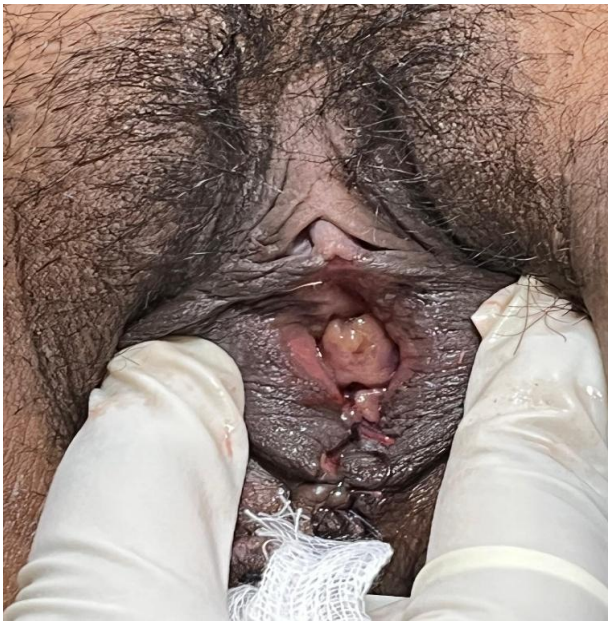

Figure 2: Urethral meatus after excision of the wart.

DISCUSSION

AUR in pregnancy is rare but important, as delayed diagnosis risks bladder overdistension, upper tract injury, and obstetric complications.[1] Most reported causes are anatomical or functional-uterine incarceration, fibroids, or neurogenic dysfunction-and a mechanical urethral lesion such as a wart is seldom the first consideration, which can delay diagnosis if the meatus is not specifically inspected. In this case, a solitary condyloma sitting across the meatus produced a ball-valve type obstruction, and its removal alone was curative, consistent with previous reports of urethral condyloma causing acute retention or bladder outlet obstruction in women, including in pregnancy.[3,4]

The differential diagnosis of a vascular urethral mass in pregnancy includes urethral caruncle, prolapse, Skene's gland cyst, urethral polyp, and, rarely, malignancy; caruncles and polyps typically lack the papillomatous surface and koilocytotic change seen on histology in condyloma.[5,6] Management should balance maternal symptom relief against fetal safety. For a solitary, obstructing lesion, wide local excision under local anaesthesia-as performed here-provides rapid, definitive relief and a histological diagnosis; ablative or cytotoxic options such as podophyllotoxin, 5-fluorouracil, or imiquimod are best avoided in pregnancy, and are in any case less suited to a single discrete meatal lesion causing obstruction.[2,7] Recurrence after excision is reported in up to 20-30% of cases owing to viral persistence, so postpartum follow-up is advisable.[7]

Vaginal delivery is not contraindicated by genital or urethral warts unless the lesions are large enough to obstruct the birth canal, since caesarean delivery does not reliably prevent vertical HPV transmission.[8] Perinatal transmission of HPV 6/11 can rarely cause juvenile-onset recurrent respiratory papillomatosis in the neonate, but this risk is low and does not by itself justify operative delivery.[8] Maternal lesions often regress spontaneously after delivery as immune tolerance reverses.[2]

CONCLUSION

This case reinforces that the urethral meatus should be examined in any pregnant woman with unexplained acute retention, and that a solitary obstructing wart can be managed safely and definitively by local excision without compromising the pregnancy.

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