



PSYCHOGENIC URINARY RETENTION (PUR) AND PERSISTENT DEPRESSIVE DISORDER (PDD) A CASE REPORT IN SAUDI ARABIA

Yasir Awadh S. Altuwairqi

Department of Internal Medicine, College of Medicine Taif University, KSA  
Associate professor & consultant of psychiatry, ORCID : 0000-0003-3321-8711

ABSTRACT

I report this unusual case in Saudi Arabia of a 26-year-old man who had a psychogenic urinary retention associated with persistent depressive disorder for the previous six years. He had symptoms of inadequate voiding stream and urine retention. After receiving the patient's medical clearance, a psychotherapy intervention was initiated. His urinary issue lingered as his mental disorder improved. This report uncovers such a case in our society and highlights the importance of body-mind interaction and consequently, the need for a biopsychosocial approach to diagnosis and treatment. Further research on this issue is still necessary, as is the use of efficient therapy.

**KEYWORDS :** Somatic Symptom Disorder, Psychogenic Urinary retention, Persistent depressive disorder.

INTRODUCTION:

Psychogenic Urinary Retention (PUR) is a condition characterized by an inability to empty the bladder due to psychological factors, it can be considered a subcategory of Somatic Symptom Disorder (SSD); a condition where patients experience significant physical symptoms that cause distress and impairment but have no identifiable medical explanation. See The DSM-5 Diagnostic Criteria for Somatic Symptom Disorder Table 1 SSD (DSM-5), previously known as undifferentiated somatoform disorder (DSM-IV), is a less specific version of somatization disorder that requires only a six-month or longer history of one or more unexplained physical complaints in addition to the other requisite clinical criteria [1].

Table 1: The DSM-5 Diagnostic Criteria for Somatic Symptom Disorder

Criterion A	1 or more physical complaints (e.g. - fatigue, loss of appetite, gastrointestinal or urinary complaints).
Criterion B	Either: 1- After appropriate investigation, the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g. - a drug of abuse, a medication) 2- When there is a related general medical condition, the physical complaints or resulting social or occupational impairment is in excess of what would be expected from the history, physical examination, or laboratory findings
Criterion C	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Criterion D	The duration of the disturbance is at least 6 months.
Criterion E	The disturbance is not better accounted for by another mental disorder (e.g., another somatoform disorder, sexual dysfunction, mood disorder, anxiety disorder, sleep disorder, or psychotic disorder).
Criterion F	The symptom is not intentionally produced or feigned (as in factitious disorder or malingering).

It is well recognized that cases that appear with many components, such as mental and physical illnesses, provide a difficult conundrum for doctors. This may be due to the intangible factors of psychological illness and its nature. This case example is representative of a number of comparable situations where the manifestation of symptoms, complications, and treatment outcomes are all significantly

influenced by the psychological aspect, both visible and unseen.

Case Presentation

A 26-year-old Saudi male presented to the psychiatry outpatient department after a referral from a urologist for evaluation of the possibility of psychogenic urinary retention. The preliminary inquiry found a 6-year history of urinary retention with no apparent cause after several clinical, imaging, and urological evaluations.

The patient reported a long history of a sense of inability to evacuate the bladder completely associated with a sense of retention, and urge to pass urine, with difficulty in initiating voiding with poor stream started at the age of 20. These symptoms started gradually and were variable from time to time. He did not seek medical attention until about 3 years ago, he consulted the urology clinic where his medical history was unremarkable except for childhood asthma, the patient reported burning of micturition and dysuria occasionally during his long medical history. There was no history of fever or febrile illness before these symptoms and no history of local rashes, urethral discharge, or lower abdominal pain.

Physical examination revealed a healthy man with no apparent physical or neurological abnormalities.

On evaluation, he had a normal complete blood count (CBC), clinical chemistry, and urine analysis as shown in Table 2, and Table 3 respectively.

Table 2: CBC & CLINICAL CHEMISTRY

N. Range	Result	Test
130 - 153	mg/dl	146 SUDIUM SERUM
0.6 - 1.3	mg/dl	1.03 CREATININE SERUM
74 - 106	mg/dl	90.3 FBS - FASTING BLOOD SUGAR
150 - 450	x1000	223 Automated Platelet Count
10 - 14	fL	8.78 Mean Platelet Volume
11.5 - 14	%	11.9 Red Cell Distribution Width
315 - 345	g/L	331 Mean Corpuscular Hemoglobin Concentration
27 - 32	(pg)	29.9 Mean Corpuscular Hemoglobin
80 - 97	fL	90.4 Mean Corpuscular Volume
43 - 53	%	52.6 Hematocrit

140 – 179	mg/dl	174	Hemoglobin Concentration
4.7 - 6.1	mil /mCL	5.82 mil	Red Blood Cell Count
5 – 10	x1000	8.04	White Blood Cell Count
3.5 - 5.3	mg/dl	4.95	POTASSIUM -SERUM
98 – 110	mg/dl	104.9	CHLORIDE SERUM
1.8 to 7.1 urea / L	mmol	1.03	UREA SERUM
0 – 32	units / L	18	SGOT - ASPARTATE TRANSAMINASE

**Table 3: URINE ROUTINE ANALYSIS:**

Range	Result	Test
<b>MACROSCOPIC</b>		
+/= 10 ML	60 ML	Volume
Yellow	DARK YELLOW	Color
Clear	HAZY	Appearance
<b>CHEMICAL</b>		
5.0 – 7.0	6.0	PH
1.003-1.035	1.027	Specific Gravity
Nil	Nil	Glucose
Nil	+	Ketones
Nil	Trace	Protein
Normal Trace	Normal Trace	Urobilinogen
Nil	Nil	Bilirubin
Nil	Nil	Blood (Hb)
Nil	Nil	Leucocytes
Negative	Negative	Nitrite
<b>MICROSCOPIC</b>		
5 to 7 cells / HPF	3-4	Pus cells / HPF
4 / HPF	0-1	RBCs / HPF
less than or equal to 15 – 20 cells / HPF	FEW	Epithelial cells
None	None	Amorphous material
None	None	Crystals
None	None	Casts
Small is normal	+	Mucus threads
Negative	Negative	Microorganisms

An **Ultrasound KUB** was done in the last year it was normal and was repeated a month later which was normal too apart from a minimally enlarged prostate. See Table 4.

**Table 4: Ultrasound KUB.**

<p><b>ULTRASOUND KUB - 01</b>                  Kidneys Both kidneys are normal in size, shape, and echo pattern with no stones, space-occupying lesions, or hydronephrosis noted.                  Urinary bladder: normal wall thickness, clear urine.                  prostate: 25 gram, homogeneous echo pattern, intact visualized capsule.                  Conclusion: Normal exam</p>
<p><b>ULTRASOUND KUB - 02</b>                  Both kidneys are within average size and size showing normal echogenicity and good cortico-medullary differentiation. No sizable stones, masses or backpressure changes.                  The urinary bladder has normal wall thickness with no calculi masses or diverticula detected                  Pre-voiding 441 ml and post residual volume small amount could not be measured by the US.                  Minimally enlarged prostate 30 mg, No masses or fluid collection.                  Conclusion: Minimally enlarged prostate with no significant residual urine.</p>

The patient took tamsulosin 0.4 mg as prescribed by the urologist for a month, but no improvement was observed. He came up at my clinic for the first time as a tall, thin man who seemed hurried and anxious. He essentially repeated his prior

history.

He did not report any psychiatric history including conversion or somatization features. There was no history of psychotic, mood, or anxiety features.

He held no job and reported a stressful life with fatigability and sleep difficulties after graduation from high school.

On mental state examination: A young somewhat uncooperative man, who appeared mildly irritable and depressed. He denied any delusional ideas or beliefs.

The patient was diagnosed with Somatic Symptom Disorder; psychogenic urinary retention and Persistent depressive disorder. He was started on fluoxetine 20 mg. The patient stated on his first follow-up appointment, two weeks later, that he had stopped taking fluoxetine because it was making his urine symptoms worse. The patient refused any further medication and was given the option of cognitive behavioral counseling in addition to social treatment and supportive psychotherapy. He did not show up regularly for outpatient appointments. On the last visit 10 days ago he still had trouble urinating and had a poor stream, but his mood disorder had improved. However, over time, the urine retention only somewhat improved. The patient's ability to function in his daily life is not noticeably affected by his urine problems, at least not yet.

**DISCUSSION**

The diagnosis of Somatic Symptom Disorder previously known as undifferentiated somatoform disorder is a less specific version of somatization disorder that requires only a six-month or longer history of one or more unexplained physical complaints in addition to the other requisite clinical criteria [1].

The highest incidence of complaints for Somatic Symptom Disorder occurs in young women of low socioeconomic status, but symptoms are not limited to any group [2].

Somatoform autonomic dysfunction is characterized by symptoms that are autonomically perceived to appear from particular organic disorders in which any medical reasoning can not explain those symptoms [3].

Pathophysiological elements behind this disorder are unclear but, in some patients with extremely infrequent toileting, the main urodynamic abnormalities were increased bladder sensation and a contractile detrusor [4].

Psychogenic causes of urinary retention, which is a sub-entity of Somatic Symptom Disorder, in adults, have been described in literature though uncommon. It is rarely described to play a role in children [5].

The association of Somatic Symptom Disorder with psychological factors was reviewed by Hoeritzauer et al., (2016) who found that among the cases of psychogenic urinary retention, there were various psychological factors like emotional deprivation during childhood, and an unhappy marriage [6].

From a psychodynamic point of view, a regression as a coping method was described in A 28-year-old woman who was diagnosed with somatoform autonomic dysfunction [3].

In individuals with urogenital somatoform autonomic dysfunction, frequent urination accompanied by lower abdominal pain is common [3].

The diagnosis of neurogenic and psychogenic dysuria is the most difficult and controversial problem of modern urology,

the solution of which requires a differentiated approach based on the comparison of neurological, psychic, and urologic symptoms [7].

Most literature studies have described a common psychogenic bladder comorbidity with anxiety and depression features [7,8,11]. Depression/anxiety is considered a risk factor for overactive bladder (OAB), this finding presumably reflects that the bladder is under emotional control [7]. OAB is an autonomic problem due to increased adrenaline. The latter is activated by Stress and anxiety too. Both cause muscles in your body to tense up. OAB causes urgency, frequency, and sometimes urge incontinence (involuntary leakage of urine).

By reviewing the literature, bladder dysfunction in depression was found to be high, up to 25.9% [8].

Patients with psychogenic bladder require multifaceted uropsychic concerns to be addressed in their care. Literature on treatment options for psychogenic urinary retention is limited. Psychological treatment has been shown to be effective in some studies.

Studies have described systematic desensitization with relaxation training and biofeedback-monitored relaxation training in these cases. The management in one case was mainly supportive of psychotherapeutic techniques including holding and containment, reassurance, advice and encouragement [9]. Also, psychosocial issues were addressed openly and communication between the family members was facilitated [10].

The psychological treatment strategy is usually based on psychodynamic intervention [3].

Moreover, there is a positive effect of psychotropic drugs (anxiolytics or antidepressants) and indifference to the use of neurologic agents [7]. On the other hand, when our patient took one antidepressant, fluoxetine, he experienced worsened bladder symptoms. Even if this calls into question the antidepressant's general usefulness in this situation, another antidepressant might be useful. The effectiveness of serotonergic or anti-cholinergic medication for ameliorating overactive bladder in patients awaits further study [8].

Given the disorder's lengthy history and its ups and downs throughout its existence, it is more likely to have a psychiatric basis. It is important to note that ruling out an organic etiology for these individuals is a top concern. If my patient returns with ongoing symptoms, he may require more testing. In addition, he has to be urged not to refuse any biological or mental medicine that may be required.

## CONCLUSION

I describe an unusual case of psychogenic urine retention, associated with persistent depressive disorder. This case can be difficult to diagnose and treat because of the psychosomatic nature of the illness. In the care of these patients, a thorough examination with an emphasis on social, psychological, and physical issues might be beneficial; biological therapy is not helpful while supportive, stress management, and social therapies are helpful options.

**Ethics mandate:** permission was obtained before reporting his case.

**Conflict of interest:** None declared

## REFERENCES:

1. American Academy of Family Physicians. Available at: <https://www.aafp.org/pubs/afp/issues/2007/1101/p1333.html>.
2. American Psychiatric Association. Diagnostic and Statistical Manual of

Mental Disorders. 4th ed. rev. Washington D.C.: American Psychiatric Association, 2000.

3. Gultom DA, Effendy E. Case Report: Somatoform Autonomic Dysfunction-Urogenital System. *Open Access Maced J Med Sci*, 2022.
4. Sakakibara R, Uchiyama T, Awa Y, Liu Z, Yamamoto T, Ito T, Yamamoto K, Kinou M, Yamaguchi C, Yamanishi T, Hattori T. Psychogenic urinary dysfunction: a uro-neurological assessment. *NeuroUrol Urodyn*, 2007.
5. Baldeu IM, Gelderen HHV. Urinary Retention without Organic Cause in Children. *British Journal of Urology*, 1983, 55:200-202.
6. Hoeritzauer I, PHE V, Panicker JN. Urologic symptoms and functional neurologic disorders. In: *Handbook of Clinical Neurology*, Vol 139, 3rd series, Edited by M. Hallett, J. Stone, and A. Carson.
7. Shvarts PG, Goriachev FK, Plotnikov AN, Savvin Dlu, Popov SV. Differential diagnosis and treatment of neurogenic and psychogenic dysuria in case of overactive bladder syndrome. *Ter Arkh*, 2013.
8. Sakakibara R, Ito T, Yamamoto T, Uchiyama T, Yamanishi T, Kishi M, Tsuyusaki Y, Tateno F, Katsuragawa S, Kuroki N. Depression, Anxiety, and the Bladder. *Low Urin Tract Symptoms*, 2013.
9. Nicolau R, Toro J, Prado CP. Behavioral treatment of a case of psychogenic urinary retention. *Journal of Behavioral Therapy & Experimental Psychiatry*, 1991, 22: 63-68.
10. Thariathu G, Chandran S, Thomas R, Raman V. Psychogenic Urinary Retention: A case report. *J. Indian Assoc. Child Adolesc. Ment. Health*, 2019; 15(3):61-67.
11. Sakakibara R, Tateno F, Tsuyusaki Y, Kishi M, Uchiyama T, Yamamoto T, et al. Psychogenic Urinary Dysfunction in Children and Adults. *Current Bladder Dysfunction Reports* volume 7, pages242–246 (2012).