

Commentary

Techniques for cystoscopy testing

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ABOUT THE STUDY

Endoscopy of the urinary bladder through the urethra is known as cystoscopy. The urethra is the tube that carries urine from the bladder to the outside of the body. Like a telescope or microscope, the cystoscope includes lenses. These lenses enable the doctor to concentrate on the urinary tracts inside surfaces. Some cystoscopes transmit images from the instrument's tip to a viewing piece at the other end using optical fibres. Cystoscopes come in a variety of sizes-from child to adult-and feature a light at the tip (Fowler, 2006). They can be as thin as a pencil or as thick as 9 mm. A lot of cystoscopes come with extra tubes to direct other surgical tools used to address urinary issues. Flexible and rigid cystoscopy are the two basic forms, and they differ in the flexibility of the cystoscope. Both sexes undergo flexible cystoscopy under local anaesthesia. Usually, a topical anaesthetic is used, most frequently xylocaine gel. Five to ten minutes before the treatment starts, the drug is injected into the urethra *via* the urinary meatus. Although rigid cystoscopy can be done under the same circumstances, it is typically done under general anaesthesia, especially on male participants because of the pain the probe causes (Griffiths, 2002).

Test procedures

In most circumstances, patients are able to eat normally and resume their daily activities after the test. Doctors may have further instructions. Before the test, patients may be requested to provide a urine sample to be tested for infection. These patients should make sure they hold their urine for a long enough time to allow them to urinate before this section of the test (Gunbey, et al., 2014). Patients will be required to remove any clothes that cover their lower bodies, though some doctors may prefer that they wear hospital gowns for the examination and cover their lower bodies with sterile drapes. Patients typically lay on their backs with their knees slightly apart. Sometimes a patient will additionally require having their knees lifted. This is especially true if you're getting a rigid cystoscopy. The patient is almost always awake during flexible cystoscopy operations, and a local anaesthetic is used to ease discomfort. Since stiff cystoscopies might be more painful, especially for men, it is common practice to administer a general anaesthesia to the patient in these situations. The region close to the urethral opening will be cleaned and given a local anaesthetic by a doctor, nurse, or technician (Jin, et al., 2016). The urinary tract is directly injected with the local anaesthesia using a tube or

needleless syringe. Skin preparation frequently involves the use of chlorhexidine. Anesthesia options for ureteroscopy patients include spinal or general (Liu, et al., 2015). The doctor will carefully place the cystoscope's tip into the urethra and then slowly raise it up into the bladder. Due to the male urethra's long length and small diameter, men experience greater pain during the treatment than women do. This portion of the test is made simpler by relaxing the pelvic muscles (Michels, et al., 2015).

A sterile liquid will progressively fill and extend the bladder through the cystoscope so that the doctor can see the bladder wall more clearly. Patients often experience some slight discomfort and the urge to urinate as the bladder fills to capacity. The time from the insertion of the cystoscope to removal may simply be a few minutes, or it may take longer if the doctor decides to remove a stone, or if a biopsy is required. The operation will take longer if a biopsy is taken. The average examination will last between 15 and 20 minutes, including preparation (Panicker, et al., 2015).

Blue light: Hexyl aminolevulinate hydrochloride is injected into the bladder as a photosensitizing agent during blue light cystoscopy. The blue light cystoscopy uses a light source that emits light through a fluid light cable attached to an endoscope in order to illuminate the area being examined. Compared to non-malignant urothelial cells, the photosensitizing agent preferentially accumulates porphyrins in cancerous cells. Neoplastic lesions glow red when illuminated with blue light, making tumours visible. The bladder's non-muscle invasive papillary carcinoma is found with the blue light cystoscopy (Ucar, et al., 2017).

References

1. Fowler CJ(2006). Integrated control of lower urinary tract-clinical perspective. *Br J Pharmacol.* 147 (S2):S14-S24.
2. Griffiths DJ(2002). The pontine micturition centres. *Scand J Urol Nephrol Suppl.*36 (4):21-26.
3. Gunbey HP, Sayit AT, Idilman IS, Aksoy O (2014). Migration of intrauterine devices with radiological findings: report on two cases. *BMJ Case Rep.*
4. Jin C, Fan Y, Zhang Q, Wang Y , Wu S, Jin J (2016). Removal of foreign bodies embedded in the urinary

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bladder wall by a combination of laparoscopy and carbon dioxide cystoscopic assistance: case report and literature review. *Investig Clin Urol.* 57(6): 449–452.

5. Liu L, Liu H, Zhang X (2015). Intravesical migration of a Chinese intrauterine device and secondary stone formation: diagnostic investigation and laparoscopic management. *Int Urogynecol J.* 26(11): 1715–1716.
6. Michels L , Blok BFM , Gregorini F, Kurz M, Schurch B , Kessler TM, Kollias S, et al(2015). Supraspinal control of urine storage and micturition in men—an fMRI study. *Cereb Cortex.* 25(10):3369–3380.
7. Panicker JN, Fowler CJ, Kessler TM (2015). Lower urinary tract dysfunction in the neurological patient: clinical assessment and management. *Lancet Neurol.* 14(7):720–732.
8. Uçar MG , Şanlıkan F, İlhan TT, Göçmen A, Çelik Ç (2017). Management of intra-abdominally translocated contraceptive devices, is surgery the only way to treat this problem? *J Obstet Gynaecol.* 37(4): 480–486.