

tion was free for 20F and the peak flow rate on uroflowmetry was 21.4 mL/s.

Conclusion: The key to successful management of severe inflammatory processes involving the bulbar urethra is correct timing of the individual steps which include surgical exploration, abscess drainage, creation of perineostomy, and urinary diversion with an indwelling urinary catheter and vesicostomy. Urethral reconstruction should be

performed with a delay of at least three months, after infectious and inflammatory processes have healed completely. Thorough nursing care is an integral component that will aid in achieving the desired result.

KEY WORDS

Foreign body, voiding cystourethrography, bulbar urethral reconstruction.