

Prostatic Abscess After Rezum: A Cautionary Case Report and Literature Review

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Case Report

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Abstract

Background

Rezum (water vapor thermal therapy) is a minimally invasive treatment for benign prostatic hyperplasia (BPH) with advantages over transurethral resection of the prostate (TURP), including lower surgical risk and less trauma. Although complications are typically mild, severe adverse events can occur.

Methods

We report a 62-year-old male with BPH who developed refractory urinary frequency, dysuria, and pelvic pain after Rezum. After poor response to medical therapy, he required secondary surgery. We also systematically reviewed randomized trials, prospective studies, case reports, systematic reviews, and meta-analyses on Rezum complications.

Results

The patient had short-term catheterization post-Rezum but developed recurrent symptoms and pelvic pain after catheter removal, severely impairing quality of life. He underwent TURP one month later. Intraoperatively, irregular necrotic tissue with cotton-like changes and scattered purulent cavities were seen in the prostatic urethra. Pathology confirmed degenerative necrosis with suppuration, establishing a prostatic abscess. Symptoms resolved after TURP. Literature review showed the most common complications were hematuria, urinary tract infection, and urethral stricture. Rare but severe complications included prostatic abscess, tissue emphysema/necrosis, and prostatic urethral cysts. Although very low in incidence, these often require reoperation and deserve clinical vigilance.

Conclusion

Although Rezum complications are often self-limiting, patients with large prostates (> 80 mL) or prior prostate biopsy remain at risk for severe infectious complications such as prostatic abscess. Enhanced surveillance, extended catheterization, and intensified antimicrobial management should be considered in high-risk patients to avoid secondary intervention.

1. Introduction

Benign prostatic hyperplasia (BPH) is an extremely common condition in aging men, leading to bladder outlet obstruction and lower urinary tract symptoms (LUTS) that can significantly impair quality of life [1, 2]. For patients with an inadequate response to pharmacotherapy or those who develop complications such as bladder dysfunction, recurrent urinary tract infections, urinary retention, or even renal impairment, surgical intervention to relieve obstruction is essential for symptom improvement. While

traditional gold-standard surgical treatments, such as transurethral resection of the prostate (TURP) and emerging laser enucleation techniques (e.g., HoLEP, ThuLEP), offer proven efficacy, they are associated with considerable surgical risks, including bleeding, infection, urinary incontinence, and sexual dysfunction [3, 4].

Transurethral water vapor thermal therapy, known as the Rezum system, has gained attention as a novel minimally invasive treatment since its introduction in 2015. This technique uses the latent heat released by water vapor to selectively and uniformly ablate hyperplastic prostatic adenomatous tissue, which is subsequently eliminated through natural apoptosis and absorption, thereby alleviating urinary obstruction [5, 6]. Multiple prospective studies and real-world data have confirmed that Rezum therapy effectively improves International Prostate Symptom Scores (IPSS), peak urinary flow rates (Q_{max}), and quality of life (QoL) scores. Rezum is particularly suitable for elderly patients, those with cardiovascular comorbidities, or individuals on anticoagulant therapy, offering advantages such as short operative time, low bleeding risk, and avoidance of general anesthesia. Notably, it demonstrates significant benefits in preserving erectile function and antegrade ejaculation, making it an appealing option for patients prioritizing functional preservation [7, 8]. However, its tissue ablation mechanism may result in residual necrotic tissue, potentially serving as a nidus for infection.

Despite its characterization as a minimally invasive and safe procedure, a spectrum of postoperative complications has been observed in clinical practice. These range from common early postoperative issues—such as lower urinary tract irritative symptoms, urinary tract infections, urinary retention, and transient hematuria—to mid- and long-term outcomes including recurrence of urinary symptoms requiring reintervention, as well as rare but clinically significant complications like urethral stricture and bladder neck contracture [7, 9]. Currently, reports on severe infectious complications and associated adverse outcomes following Rezum therapy remain scarce. Furthermore, systematic analyses of their incidence, risk factors, pathogenesis, preventive strategies, and management are lacking.

This article presents a case of prostatic abscess following Rezum therapy managed at the Department of Urology, The Second Hospital of Dalian Medical University, and provides a comprehensive review and synthesis of the literature regarding common postoperative complications and rare adverse outcomes associated with this procedure, aiming to inform clinical practice.

2. Case Report

A 62-year-old male was admitted to the hospital in November 2025 with chief complaints of "urinary frequency, urgency, and progressive dysuria for 2 years, worsening over the past month." Digital rectal examination revealed a prostate with a soft consistency and no palpable nodules. Laboratory results were as follows: total prostate-specific antigen (t-PSA): 5.357 ng/mL; free-to-total PSA ratio (f/t PSA): 13.68%; Prostate Health Index (PHI): 28.58. Imaging studies: Magnetic resonance imaging (MRI) of the prostate demonstrated prostate dimensions of 5.3 × 5.2 × 5.16 cm, corresponding to a volume of approximately 80.25 mL, with a Prostate Imaging Reporting and Data System (PI-RADS) score of 3.

Uroflowmetry showed a maximum urinary flow rate (Qmax) of 5.7 mL/s, and post-void residual urine volume was 64 mL.

The patient strongly desired preservation of sexual function and declined a preliminary prostate biopsy to rule out malignancy. Consequently, he opted to undergo simultaneous transrectal ultrasound-guided prostate biopsy and transurethral water vapor thermal therapy (Rezüm). Under ultrasound guidance, a total of 16-core prostate biopsy was performed. Subsequently, cystoscopy revealed trilobar prostatic hyperplasia occupying approximately 5–6 cystoscopic fields, with mild compression of the posterior urethra. The distance from the bladder neck to the verumontanum was approximately 4 cm, and the bladder neck was mildly elevated. Water vapor thermal ablation was administered as follows: one injection each at the 2, 3, and 5 o'clock positions of the left prostatic lobe, approximately 1.5 cm from the bladder neck. The right lobe was treated in a similar manner. Additionally, one supplemental injection was delivered to areas of prominent adenomatous hyperplasia in each lateral lobe, resulting in a total of 8 treatment injections. Intraoperative bleeding was minimal.

Postoperative pathology results confirmed benign prostatic hyperplasia. Indwelling catheterization for 2 weeks was recommended. However, due to catheter-related discomfort, the catheter was removed at an external hospital on postoperative day 3. Immediately following catheter removal, the patient developed voiding difficulties, characterized by a weak stream, urinary hesitancy, nocturia (3–4 times per night), persistent dysuria, urethral burning sensation, and occasional urinary incontinence. Gross hematuria, fever, and chills were absent. Oral antibiotic and antispasmodic therapy provided no significant symptomatic improvement.

One month post-Rezum, the patient returned for follow-up. Urine culture revealed growth of *Enterococcus faecalis*. Given the refractory dysuria and persistent bladder outlet obstruction severely impacting quality of life, and the failure of conservative medical management, transurethral resection of the prostate (TURP) was performed. Intraoperative findings included pallor of the prostatic urethral mucosa, irregular necrotic tissue with a cotton-like appearance, partial separation of the central and peripheral zones forming flap-like structures, and scattered purulent cavities with purulent exudate visible on the cut surface of the tissue (Fig. 1). Focal follicular elevations with reduced vascularity were observed at the bladder neck. The bladder lumen appeared turbid, with scattered trabeculations; both ureteral orifices were normal, and the bladder mucosa showed no evidence of abnormal congestion or neoplasms. The purulent cavities were unroofed, and the necrotic tissue was extensively resected.

Postoperative pathology confirmed benign prostatic hyperplasia with degenerative necrosis and evidence of suppuration in the resected tissue (Fig. 2). Following one week of postoperative antibiotic therapy, the indwelling catheter was removed. The patient subsequently voided with a good stream, and there was no recurrence of dysuria, voiding difficulties, or urinary incontinence.

3. Discussion

Transurethral water vapor thermal therapy (Rezüm), a minimally invasive treatment for benign prostatic hyperplasia (BPH), achieves tissue ablation through the convective delivery of sterile water vapor (approximately 103°C) directly into the prostatic tissue [10]. Since its introduction, Rezüm has been progressively adopted in clinical practice worldwide. It is primarily indicated for patients with moderate to severe lower urinary tract symptoms (LUTS) secondary to BPH, particularly those with an inadequate response to, or intolerance of, pharmacological management. The procedure effectively relieves bladder outlet obstruction and improves voiding function [6, 11].

Current guidelines recommend Rezüm for prostates with volumes ranging from 30 to 80 mL. In 2024, Emilio López Alcina and colleagues, through statistical analysis of existing clinical studies and a multi-disciplinary expert consensus on the appropriate prostate volume for Rezüm, concluded that water vapor thermal therapy is suitable for prostates measuring 30–80 cm³ as well as those > 80 cm³ [12]. However, clinical experience with Rezüm in large-volume prostates remains limited.

The number of injections during a Rezüm procedure is primarily determined by the length of the prostatic urethra and is adapted to the morphology of the hyperplastic gland, potentially including the median lobe or an enlarged central zone. Under direct visualization, the delivery needle is positioned starting at the bladder neck and advanced into the prostatic tissue in approximately 1 cm increments, continuing up to the proximal verumontanum [12]. In the present case, the calculated prostate volume was approximately 80 mL, meeting the treatment indication for Rezüm. The intraoperative injection pattern followed the manufacturer's (Boston Scientific) product guidelines, recommending 3–4 injections per lateral lobe, with an additional 1–2 injections delivered to areas of prominent adenomatous hyperplasia, which aligns with current treatment consensus.

Postoperative complication rates following Rezüm are low, and events are predominantly mild to moderate in severity; however, severe adverse events have been reported. The incidence of postoperative hematuria ranges from 6.5% to 52.5% and is typically self-limiting. Hematuria may be associated with the patient's underlying coagulation status, mechanical trauma to the prostate during the procedure, or disruption of prostatic blood vessels. A related adverse outcome is prostatic hematoma, of which only one case has been clinically reported to date [13]. Although Rezüm causes minimal trauma to the prostatic urethra, the possibility of localized intraparenchymal bleeding with inadequate drainage, potentially leading to hematoma formation and subsequent infection or abscess, cannot be entirely excluded.

Urinary tract infections (UTIs) following Rezüm primarily manifest as irritative bladder symptoms, including urinary frequency, urgency, and dysuria. Some patients may present with fever, flank pain, or cloudy urine. In severe cases, UTIs can progress to acute pyelonephritis or sepsis. The reported incidence of UTI after Rezüm ranges from 5.5% to 18.1% [14, 15]. The development of post-Rezüm UTIs is associated with several factors: indwelling catheterization disrupts the normal urethral physiological barrier, facilitating bacterial ascent along the catheter; surgical trauma to the urethral mucosa and prostatic tissue compromises local host defenses, creating a milieu conducive to bacterial proliferation;

patient-specific factors, such as a history of chronic UTI, diabetes mellitus, or immunodeficiency, increase postoperative infection risk; and suboptimal catheter care, including failure to maintain a clean drainage bag or timely catheter changes, may also contribute to infection rates.

A real-world study including 181 patients with BPH treated with the Rezum system reported a UTI incidence of 5.5% and a prostatitis symptom rate of 2.2% [14]. The mean postoperative catheterization duration was approximately 8 days, suggesting that a longer catheterization period may be a significant contributing factor to infectious complications. This study further emphasizes that while UTI rates are not exceedingly high, they remain a noteworthy complication following water vapor thermal therapy.

David Midlick in the United States reported a case of an immunocompetent patient who developed *Citrobacter* and vancomycin-resistant *Enterococcus faecalis* (VRE) bacteremia following Rezum [16]. The patient presented with hematuria, fever, and chills on the day after the procedure, ultimately being diagnosed with *Citrobacter* infection and VRE bacteremia. This represented the first reported instance of bacteremia occurring after Rezum.

Prostatic tissue necrosis is an intended therapeutic effect of water vapor thermal ablation, typically confined to the prostatic fossa. However, necrotic tissue can serve as a favorable nidus for bacterial colonization, potentially exacerbating UTIs and, in some cases, progressing to prostatic abscess, systemic infection, or bacteremia. Excessive tissue necrosis or abnormal sloughing of necrotic debris may manifest clinically as persistent gross hematuria, severe perineal pain, or worsening voiding difficulties. In severe instances, necrotic tissue can obstruct the urethra, or even form emphysematous necrotic debris balls, often necessitating secondary surgical intervention.

Mansour Alnazari described a novel finding following Rezum treatment: an emphysematous necrotic debris ball secondary to gas-forming organism infection. The patient, who had negative preoperative urine cultures and received prophylactic antibiotics, underwent outpatient Rezum with suprapubic tube placement for 2 weeks. Following uneventful removal of the suprapubic tube and initial successful voiding, the patient subsequently developed severe urinary frequency, urgency, intermittent stream, dysuria, and fever. Ultrasound revealed multiple hypoechoic areas with gas within residual soft tissue in the bladder. Cystoscopy and debridement of necrotic tissue were performed, and postoperative tissue cultures confirmed *Klebsiella* colonization [17]. The authors hypothesized that prolonged catheterization likely contributed to the development of the UTI.

Prostatic abscess is a rare but potentially life-threatening genitourinary infection. The overall incidence reported in the literature accounts for up to 0.5% of all urologic diseases, with a mortality rate ranging from 1% to 16% [18]. Approximately 2.7% of patients with acute bacterial prostatitis may develop prostatic abscess [18]. It is most commonly observed in elderly patients with diabetes mellitus. Other predisposing factors include prolonged catheterization, recent prostate manipulation, urethral obstruction, and immunocompromised states.

Reports of prostatic abscess specifically following minimally invasive surgical therapies for BPH are scarce. In a study comparing short-term outcomes of transperineal laser ablation (TPLA) versus water vapor thermal therapy, one patient in the TPLA group developed a postoperative prostatic abscess classified as Clavien-Dindo grade ≥ 3 . Prostatic abscess was the most common CD > 2 complication following TPLA, consistent with existing clinical reports [10]. However, well-documented cases of prostatic abscess specifically attributable to Rezum therapy are lacking. In 2018, Jennifer Fantasia first reported an adverse outcome following Rezum that was radiologically identified as a prostatic abscess [19]. In that reported case, the patient presented three months post-Rezum with fever, gross hematuria, and suprapubic pain unresponsive to antibiotics. Based on imaging findings, a preliminary diagnosis of prostatic abscess was made. The patient improved following TURP and catheter drainage; however, while final pathology indicated extensive infarction and acute inflammation, it did not definitively confirm prostatic abscess. The present case, to our knowledge, represents the first reported instance of a pathologically confirmed prostatic abscess following Rezum therapy, necessitating secondary surgical intervention.

Prolonged catheterization is not typically required after Rezum. WVT guidelines generally recommend postoperative catheterization for 5 to 7 days. However, based on clinical observations and relevant literature, the duration of indwelling catheterization may need to extend beyond 5–7 days, varying according to prostate size and the number of injections administered [12]. Therefore, we recommended a 2-week indwelling catheterization period in this case to facilitate the sloughing or absorption of necrotic tissue and to avoid voiding discomfort or difficulties.

In the present case, several factors likely contributed to the development of the prostatic abscess. The patient's relatively large prostate volume (80 mL) resulted in a greater burden of necrotic tissue following ablation, potentially overwhelming the body's absorptive and clearance capacity and leading to a pronounced inflammatory response. The concurrent prostate biopsy may have introduced bacteria into the deep prostatic tissue, increasing the risk of infection. Furthermore, the premature removal of the indwelling catheter on postoperative day 3, before adequate sloughing of necrotic tissue, likely contributed to urinary obstruction, increased post-void residual urine, and subsequent bacterial proliferation. The identification of *Enterococcus faecalis* suggests possible ascending infection from the intestinal flora, consistent with the mechanism of catheter-associated urinary tract infections.

To mitigate the risk of such complications, several preventive strategies should be considered during water vapor thermal therapy. Excessive prostatic tissue necrosis should be avoided through precise parameter setting: a personalized ablation plan should be developed preoperatively based on prostate volume and tissue characteristics, with strict control over the dose, temperature, and duration of each water vapor injection. Intraoperatively, dynamic observation of tissue changes allows for timely adjustment of ablation parameters. Postoperatively, close monitoring of patient symptoms is essential, and the duration of catheterization should be judiciously determined. For patients presenting with persistent hematuria or severe pain, prompt imaging evaluation is warranted to assess the extent of tissue necrosis, and timely transurethral debridement of necrotic tissue should be performed when

indicated. Given the variability in patient immune status and intraoperative factors, future research should explore individualized preventive strategies to optimize postoperative recovery outcomes.

4. Conclusion

Transurethral water vapor thermal therapy (Rezüm), as a minimally invasive technique for the treatment of benign prostatic hyperplasia, offers advantages including reduced trauma, rapid recovery, and proven efficacy. However, postoperative adverse events such as hematuria, voiding difficulties, and urinary tract infections may still occur. The development of these adverse outcomes is associated with multiple factors, including surgical technique, perioperative management, and individual patient characteristics. Although prostatic abscess following Rezüm is rare, it may occur in high-risk patients, such as those with large prostate volumes, concurrent prostate biopsy, or suboptimal catheter management. Clinicians should strictly adhere to appropriate patient selection criteria, standardize perioperative infection prevention and control measures, individualize the duration of catheterization, and enhance imaging evaluation in patients with persistent postoperative urinary tract infections to enable early detection and timely management of such severe complications.

Declarations

Data availability

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request. Data is provided within the manuscript or supplementary information files. Written informed consent for publication of their clinical details and/or clinical images was obtained from the patient. Ethics approval and consent to participate This study was conducted in accordance with the principles of the Declaration of Helsinki.

Author contributions

Study concept and design: Bo Yang.

Data acquisition: Chunming Wang.

Drafting of manuscript: Chunming Wang, Xiang Gao.

Critical revision of the manuscript: Bo Yang, Xiang Gao.

Final approval of manuscript: Bo Yang.

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Conflicts of interest

The authors declare no conflict of interest.

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Ethics approval and consent to participate

This study was conducted in accordance with the principles of the Declaration of Helsinki.

Consent for publication

Written informed consent was obtained from the participants for publication of the details of their medical case and any accompanying images.

References

1. Inamura S, Terada N. Chronic inflammation in benign prostatic hyperplasia: Pathophysiology and treatment options. *Int J Urol.* 2024;31(9):968–74. 10.1111/iju.15518. <https://pubmed.ncbi.nlm.nih.gov/38934050/>.
2. Tsunemori H, Sugimoto M. Effects of inflammatory prostatitis on the development and progression of benign prostatic hyperplasia: A literature review. *Int J Urol.* 2021;28(11):1086–92. 10.1111/iju.14644. <https://pubmed.ncbi.nlm.nih.gov/34342061/>.
3. Zeng XT, Jin YH, Liu TZ et al. Clinical practice guideline for transurethral plasmakinetic resection of prostate for benign prostatic hyperplasia (2021 Edition). *Mil Med Res.* 2022;9(1):14. Published 2022 Apr 1. 10.1186/s40779-022-00371-6 <https://pubmed.ncbi.nlm.nih.gov/35361280/>
4. Nguyen DD, Li T, Ferreira R, et al. Ablative minimally invasive surgical therapies for benign prostatic hyperplasia: A review of Aquablation, Rezum, and transperineal laser prostate ablation. *Prostate Cancer Prostatic Dis.* 2024;27(1):22–8. 10.1038/s41391-023-00669-z. <https://pubmed.ncbi.nlm.nih.gov/37081044/>.
5. McVary KT, Gittelman MC, Goldberg KA, et al. Final 5-Year Outcomes of the Multicenter Randomized Sham-Controlled Trial of a Water Vapor Thermal Therapy for Treatment of Moderate to Severe Lower Urinary Tract Symptoms Secondary to Benign Prostatic Hyperplasia. *J Urol.* 2021;206(3):715–24. 10.1097/JU.0000000000001778. <https://pubmed.ncbi.nlm.nih.gov/33872051/>.
6. León Mata J, Sousa González D, Álvarez Casal M, Sousa A. Analysis of the Tolerance and Safety of the Rezum System for the Treatment of Benign Prostatic Hyperplasia. *Arch Esp Urol.* 2025;78(8):926–38. 10.56434/j. arch.esp.urol.20257808.123 <https://pubmed.ncbi.nlm.nih.gov/41111362/>.
7. Singh D, Nguyen T, Burnam P, Greenberg J, Raheem O, Hellstrom W. Benign Prostatic Hyperplasia and Sexual Dysfunction: Review of the Impact of New Medical and Surgical Therapies on Sexual

- Health. *Curr Urol Rep.* 2025;26(1):49. 10.1007/s11934-025-01279-z. Published 2025 Jun 9. <https://pubmed.ncbi.nlm.nih.gov/40490610/>.
8. Lopategui DM, Shah HN, Herrmann TRW. Antegrade ejaculation preservation in surgical treatment for benign prostatic hyperplasia: quest for balance between voiding and sexual function. *Curr Opin Urol.* 2024;34(4):286–93. 10.1097/MOU.0000000000001178. <https://pubmed.ncbi.nlm.nih.gov/38595170/>.
 9. Law YXT, Chen WJK, Shen L, et al. Convective Water Vapor Energy Ablation (Rezūm®) Versus Prostatic Urethral Lift (Urolift®): A 2-Year Prospective Study. *J Endourol.* 2024;38(12):1387–94. 10.1089/end.2024.0400. <https://pubmed.ncbi.nlm.nih.gov/39302046/>.
 10. Pacini M, Zucchi A, Salonia A, Sollazzi E, Macrì G, Volterrani R, Bini V, Antonov P, Ivanov A, d'Arma A, De Nunzio C, Bartoletti R. Short term results after minimally invasive treatments for benign prostatic enlargement: the first randomized trial comparing transperineal laser ablation and water vapor ablation. *Prostate Cancer Prostatic Dis.* 2025;28(4):978–84. <https://doi.org/10.1038/s41391-025-00972-x>.
 11. Das A, Morgan KL, Yafi F. Water Vapor Thermal Therapy: Minimally Invasive Treatment for Benign Prostatic Hyperplasia. *J Endourol.* 2022;36(S2):S6–11. <https://doi.org/10.1089/end.2022.0424>.
 12. Alcina EL, Arjona MF, Guzmán EF, Zuazu JR, Jochamowitz IS. Expert consensus on Rezūm™: Indications, surgical technique and postoperative care. *BJUI compass.* 2025;6(2):e491. <https://doi.org/10.1002/bco2.491>.
 13. Alkeraithe F, Hamri B, Alsaleh S, F., Alasmari F. Unexpected encapsulated hematoma after Rezūm therapy: First outcome of an emerging therapy. *Urol case Rep.* 2022;44:102125. <https://doi.org/10.1016/j.eucr.2022.102125>.
 14. Pang MY, Wei Y, Lin JZ, Wang J, Liu MY, Liu FY, Ma YB, Zhao T, Zhu QY. Zhonghua nan ke xue = National. *J Androl.* 2025;31(7):603–7.
 15. Bitar Siqueira MH, Jakubowicz D, Ferreira R, Shprits S, Buksh O, Bhojani N, Chughtai B, Zorn KC, Cindolo L, Ferrari G, Gatti L, Lajkosz K, Elterman D. Rezūm water vapor thermal therapy for large-volume (≥ 80 mL), symptomatic, benign prostatic enlargement: Large, multicenter, real-world cohort with two-year followup. *Canadian Urological Association journal = Journal de l'Association des urologues du Canada*; 2025. 10.5489/cuaj.9336. <https://doi.org/10.5489/cuaj.9336>. Advance online publication.
 16. Midlick D, Harhay J, Summers NA. Carbapenem-resistant *Citrobacter amalonaticus* and VRE bacteraemia in an immunocompetent patient after a urological Rezūm procedure. *Access Microbiol.* 2024;6(10):000852v4. <https://doi.org/10.1099/acmi.0.000852.v4>.
 17. Alnazari M, Bakhsh A, Rajih ES. Emphysematous sloughed floating ball after prostate water vaporization Rezūm: A case report. *World J Clin Cases.* 2023;11(23):5525–9. 10.12998/wjcc.v11.i23.5525.
 18. Pishdad R, Sullivan S, Mohammadi O. (2021). Prostatic abscess. *CMAJ: Canadian Medical Association journal = journal de l'Association medicale canadienne*, 193(8), E290.

19. Fantasia J, Ili B, Amin J, A., Pareek G. Anticipated treatment defect versus prostatic abscess: radiographic findings following transurethral convective radiofrequency-induced water vapor thermal ablation. *Can J Urol*. 2018;25(4):9424–6.

Figures

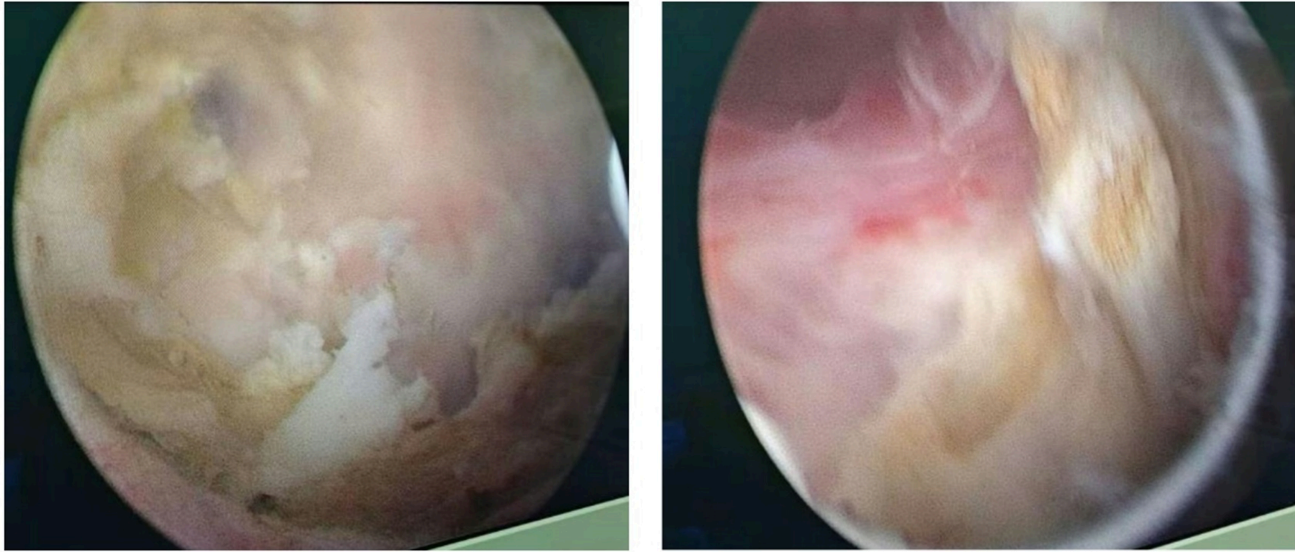


Figure 1

Intraoperative finding 1 month post-Rezum

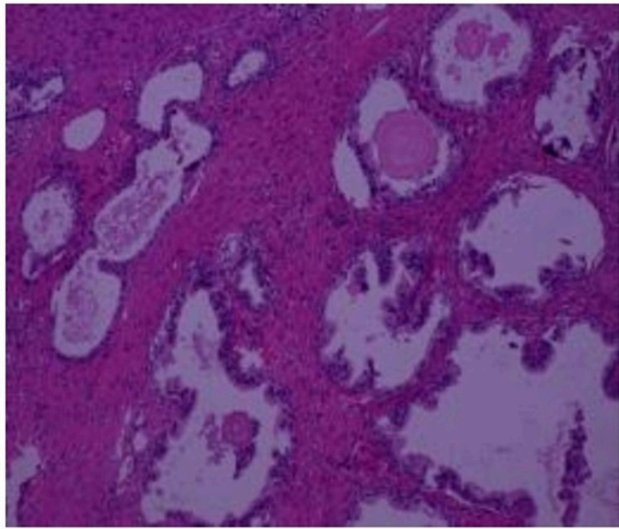


Figure 2

Postoperative pathological findings