

### The timeline of this case

Time	affairs
2010.07.27	The patient underwent ureteroscopic lithotripsy
2010.07.30	The patient complained of frequency and urgency
2020.08.23	Ultrasonography showed the bladder wall was thickened and rough with multiple strong echogenic spots attached to it (Figure 1A).
2010.08.30	The patient complained of frequency and urgency, dysuria, gross hematuria, microlith expulsion, putrefaction expulsion, and suprapubic pain.
2010.08.23- 2020.09.03	The patient received empirical antituberculosis treatment.
2010.09.01	Cystoscopy showed diffuse white necrotic tissue in the bladder wall and flocculent substance in the bladder cavity.
	Histopathological examination showed inflammatory granulation tissue on the bladder wall, with local necrosis and calcification (Figure 2A, B).
2010.09.15	Cystoscopy showed reduced bladder volume, swollen, congested and stiff bladder wall, multiple calcifications seen, no typical miliary nodules.
	Histopathological examination showed chronic inflammation and epithelial hyperplasia of bladder mucosa. Calcium deposition, proliferation of fibrous tissue, and infiltration of neutrophils, eosinophils and lymphocytes were observed in the lamina propria of the bladder mucosa (Figure 2C, D).
2010.07.31- 2010.09.25	The patient received a variety of antibiotics with poor efficacy.
2010.09.25	The patient visited our hospital and started related medical

	examination.
	CT showed that the bladder wall had extensive thickening and many calcifications attached to it (Figure 3A).
	Intravenous pyelography showed that the bladder was gourd-like with a rough margin, and hydronephrosis was found in the left upper urinary tract (Figure 3B).
2010.10.08	Cystoscopy showed a marked inflammatory appearance of all parts of the bladder mucosa with ulcerations and whitish plaques corresponding to multiple encrusted calcifications (ECs) (Figure 4)
	Endoscopic removal of encrustations was performed. Sefamandole (2 g bid) was administered for 3 days, solifenacin (5 mg qd) was administered for 1 wk. Hyaluronic acid (HA) bladder instillations (50 mL qw) was administered for 1 mo.
	Infrared spectrophotometry: struvite.
	Histopathological examination: showed that the bladder mucosa was edematous and necrotic, with many encrusted crystals and a polymorphonuclear infiltrate forming a thick conglomerate (Figure 2E, F).
	The patient's symptoms were relieved slightly. He needed to go for micturition every 30 min.
2010.11.10	Cystoscopy showed that the top and bilateral bladder wall mucosa still had hyperemia, edema, ulceration and multiple ECs (Figure 5).
	The second endoscopic removal of encrustations was performed. Ceftriaxone sodium (1g bid) was administered for 3 days, and solifenacin (5 mg qd) and HA ( 50 mL q2w) were administered for 1 mo.
	The patient's symptoms were further relieved.

2010.12.08	Cystoscopy showed that the ulcers on the top and bilateral bladder wall were cured, but there were still a few ECs on the mucosa (Figure 6).
	The third endoscopic removal of encrustations was performed. Cefamandole (2 g bid) was administered for 5 days, solifenacin (5 mg qd) and HA (50 mL q4w) were administered for 2 mo.
2011.02.16	The patient's dysuria, gross hematuria and suprapubic pain symptoms were relieved. He needed to go for micturition every 70 min, voiding 100–150 mL each time. However, he still complained of obvious frequency and urgency.
	Cystoscopy showed no mucosal ulcers, but there were still a few mucosal encrustations on the top and bilateral bladder wall (Figure 7).
	The fourth endoscopic removal of encrustations was performed. Cefamandole (2 g bid) was administered for 5 days.
	Because he still complained of frequency and urgency, he received botulinum-A neurotoxin (BoNT/A) therapy.
2011.05.16	The patient was cured. He needed to go for micturition 6–7 times during the daytime and once during the night, with a volume of 300–400 mL each time.
	Urinalysis was normal. Ultrasonography showed there were still a few of strong echogenic spots attached to the bladder wall.
2012.02.08	No recurrence. He needed to go for micturition 4–7 times during the daytime, with a volume of 300– 500mL each time, and did not need to go for micturition at night.
	Ultrasonography showed smooth bladder wall with no

	hyperechogenic material on it (Figure 1C).
2020.03.20	No recurrence.