

Case Report

Management of rectal foreign body with endoscopic snare: a case report

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ABSTRACT

Foreign bodies in the rectum, although not much common present a challenging task to the surgeons for retrieval. Depending on the type and position they can cause anorectal trauma and perforative peritonitis. Diagnosis is usually by history, per rectal examination and radiography. Here authors present a 27-year-old male who came with history of insertion of candle into rectum to prevent bleeding from haemorrhoids. Perforative peritonitis was ruled out and manually tried to remove it and all attempts failed. He was posted for colonoscopy and it revealed 23cm long candle in the rectum with bleeding anal tag. The tip of candle extended into sigmoid colon. Polypectomy snare applied around the candle and foreign body was gently removed. Check colonoscopy revealed no significant injury. He was referred to psychiatry department and he was discharged the next day.

Keywords: Colonoscopy, Haemorrhoids, Polypectomy snare, Radiography

INTRODUCTION

Intentional or unintentional insertion of foreign bodies in rectum is not uncommon and it presents a challenging task to clinician. Mostly the patients are male with different age groups. They are usually inserted for sexual purposes or could be due to criminal assault or self-treatment of ano-rectal diseases.^{1,2}

Few cases in the literature described foreign bodies in the rectum in association with Munchausen's syndrome in psychiatry patients.^{3,4} Barrel shaped (cylindrical) objects are more common, since they can be easily inserted. In the literature many common as well as exotic objects which have been inserted through the anus, were recorded, which included light bulbs, candles, shot glasses, unusually large objects such as soda or beer bottles.⁵

These patients commonly present with pain, discomfort or foreign body sensation. They present to the doctor

after their attempts to remove the object fail. Social embarrassment and stigmas hinder the patient to seek immediate medical care. Patients may come up with unusual stories to explain how the object was lodged in the rectum.⁶

CASE REPORT

A 27-year-old male presented with foreign body in the anus. H/o similar activity in the past for hemorrhoidal bleeding with vegetables two weeks back.

There was no history of vomiting, diarrhea, fever or bleeding per rectum. General and systemic examinations were essentially normal. On examination lower edge of the candle was felt in the rectum 6 cm above the anal verge, upper body could not be felt. Foreign body could not be visualised on proctoscopy. There was no active bleeding. There were no perianal bruises. Anal sphincter tone was normal. Perforation was ruled out and X-Ray abdomen revealed shadow of candle in lower abdomen.

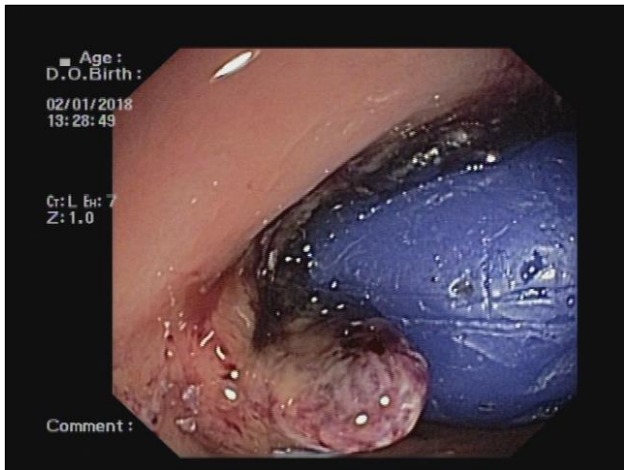


Figure 1: FB rectum with anal tag.

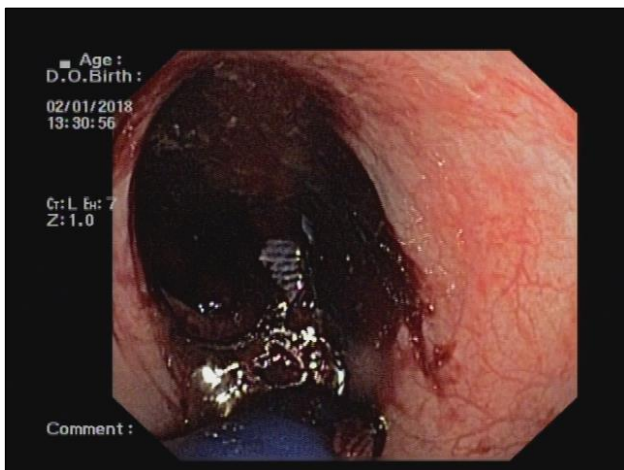


Figure 2: Tip extending up to sigmoid colon.

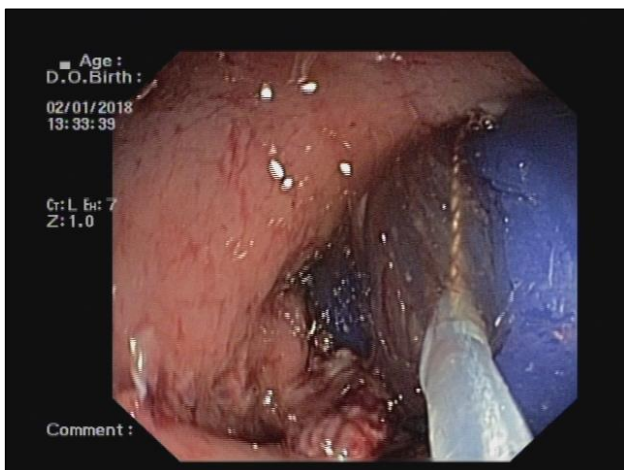


Figure 3: Snaring applied from below.

Management

Attempt to digital remove the object was made in the examination room with liberal surface anaesthesia but was not successful. He underwent colonoscopy which

showed blue colour candle which measured 23 cms in length. The candle was broken and curved which helped in extension up to sigmoid colon.



Figure 4: Extracted foreign body (candle) measuring 23 cm.

During colonoscopy candle was grasped with Polypectomy snare and with digital manipulation of curved candle at recto sigmoid junction, it was gently pulled out. Check colonoscopy was normal with no mucosal injury. Patient was discharged the next day after tolerating oral diet and Psychiatrist counselling.

DISCUSSION

The incidence of rectal foreign bodies is most commonly seen in Eastern Europe but uncommon in Asia⁶ Usually seen in young people in twenties (mostly for sexual pleasures) but also in elderly people (mostly for the therapeutic purposes). Ano rectal foreign bodies are common in males than in females.^{7,8}

A detailed clinical history and physical examination plays major role in diagnosis and management of these patients. The patient may be asymptomatic or may present with florid peritonitis which depends upon the type of rectal foreign bodies, method of insertion, duration and presence of non-professional intervention to remove these bodies. Patients mostly present with anal pain and bleeding (66.7%). A careful abdominal examination should be performed to assess signs of peritonitis or ability to palpate the object per abdomen.

Eftaiha et al classified foreign bodies in rectum as high lying or low lying depending on its relation with rectosigmoid junction.⁹ Objects lying above recto-sigmoid junction are considered high lying and are difficult to remove per-rectally even with procto-sigmoidoscope. Similarly, Kingsley et al also reported that those foreign bodies in low or mid rectum up to a level of 10 cm can be most often removed transanally while those above 10 cm may require laparotomy for retrieval.¹⁰ As per Barone et al assigned prognostic categories based on levels of injury.¹¹

- Category I: Retained foreign body without injury.
- Category II: Retained foreign body with mucosal laceration.

- Category III: Retained foreign body with sphincter injury.
- Category IV: Retained foreign body with rectal perforation.

Complications of foreign body rectum include rectal bleeding, mucosal laceration, bowel perforation, abscess and rarely death.¹² Management include is ruled out by clinical examination, X ray and if necessary CT scan abdomen. Plain radiography helps is identifying foreign body and rule out perforation.¹³

Majority (90%) of the cases are treated trans anal retrieval.¹⁴ Colonoscopy removal is reported with good success. Laparotomy may be necessary in cases of impacted foreign body or with perforation peritonitis. The laparoscopic approach helps in easy removal, detection of rectal injury, and early discharge.¹⁵ Bak et al described a novel approach to retrieval and removal of a rectal FB utilizing a single-incision laparoscopic surgery port.¹⁶

In present case authors used a polypectomy snare to grab the foreign body and retrieved it with digital manipulation.

CONCLUSION

Rectal foreign bodies present as an embarrassment for the patient and diagnostic and treatment dilemma to the doctor. Delay in presentation with multiple attempts of self-removal lead to mucosal edema and muscular spasms further hindering removal. Patient evaluation needs a systemic approach in diagnosing perforative peritonitis. Care should be taken not to cause further damage while removing the foreign body. Laparotomy should be reserved for patients with perforation or failed trans anal attempts. All patients should also undergo psychological evaluation to avoid similar episodes in the future.

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