

Case Report

Rectal foreign body: case report and review of literature

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Received: 10 August 2016

Accepted: 10 September 2016

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ABSTRACT

We present a case report of an unusual large foreign body in Rectum. Our patient presented with signs of intestinal obstruction following insertion of plastic oil bottle in the rectum for breaking fecal impaction. Patient was then evaluated and transanal retrieval of foreign body was carried out successfully.

Keywords: Foreign body, Rectum, Fecal desimpaction, Intestinal obstruction, Transanal retrieval

INTRODUCTION

Rectal foreign bodies are not uncommon in emergency departments around the world. The incidence said to be on lower side in Asia and more common in Eastern Europe.¹ Typically patients are male. The age group is 16-80 years.² There is a bimodal age distribution, observed in the second decade for anal erotism, and in the sixth decade mainly for prostatic massage and for breaking fecal impaction.³ The majorities of such objects are introduced through the anus and are the result of sexual misadventures. Occasionally a foreign body may be ingested and successfully passes the entire gastrointestinal tract and held up in the rectum. Numerous objects, including various fruits and vegetables, nails, light bulbs, bottle, body spray cans, dildoes and vibrators; have been described as retained rectal foreign bodies.^{4,5} Reluctance to seek early medical advice and embarrassment to share details about the incident often makes diagnosis delayed and challenging. We reported a case of a long-standing retained foreign body a large plastic oil bottle in the rectum, which presented as intestinal obstruction.

CASE REPORT

A 65-year-old man was admitted to the emergency department with the history of abdominal pain, vomiting, distension of the abdomen and constipation since 4 days. He has given history of insertion of plastic oil bottle in the rectum 5 days back for desimpaction of hard stool. No history of bleeding per rectum. He underwent surgery for perianal fistula 5 years back. On examination abdomen was distended, nontender with hyper peristaltic sounds on auscultation. Signs of peritonitis were absent. On per rectal examination his anal sphincter was lax and foreign body palpated in the rectum. On clinical examination his vitals were stable plain radiograph of pelvis and abdomen was done which shows a bottle in the rectum with entrapped air inside (Figure 1). Laboratory parameters were normal. Patient was taken in the operation theatre and Transanal removal of the large plastic bottle done with the help of sponge holder under spinal anaesthesia (Figure 2 and 3). Flexible endoscopy was done to confirm presence of any mucosal injury. Postoperative recovery was uneventful.

DISCUSSION

Rectal foreign bodies occasionally presents to the emergency surgical department. Males are commonly

affected. Incidence is more common in European countries as compared to Asian countries.¹ Some authors reported incidence is increasing in Asian countries as well. More than two-thirds of patients with rectal bodies are men in their third and fourth decade. Patients as old as 90 years were also reported.² Most of the time rectal foreign bodies are objects that are inserted voluntarily and for sexual gratification. The foreign bodies commonly reported were, various fruits and vegetables, nails, light bulbs, bottle, dildos and vibrators, axe handle, body spray cans, wooden, or rubber objects.^{4,5} Involuntary sexual foreign bodies are almost exclusively seen in the cases of rape and sexual assault. One of the most common types of rectal foreign body is best known as body packing and is commonly used by drug traffickers.⁴ Involuntary nonsexual foreign bodies are usually seen in the elderly, children, or the mentally ill. The objects are usually retained thermometers and enema tips, and orally ingested objects, such as chicken bones, plastic objects such as erasers or pill bottle caps, tooth picks, and even coins or small plastic toys. All these foreign bodies have potential to cause significant injury to rectum and colon.⁴



Figure 1: X-ray pelvis showing gas filled bottle in the rectum.



Figure 2: Transanal extraction bottle with help of sponge holder.



Figure 3: Plastic bottle tapering tip.

Patient usually present Pelvic pain, bleeding per rectum, rectal mucoid discharge, sometimes incontinence or bowel obstruction can be the presenting symptoms.³ Patient may present with acute abdominal pain, if perforation has occurred above the peritoneal reflection. One should always keep in mind that patient with foreign body may be embarrassed to reveal the true reason for their visit to seek medical care. Usually have late presentation for hours, even days, in hope of spontaneous foreign body passage. Many patients have attempted to remove the object by themselves unsuccessfully prior seeking medical care. It is important to maintain a high degree of suspicion should someone present with the aforementioned symptomatology. Physical examination of abdomen should be done carefully to rule out peritonitis. A rectal examination should be performed, to assess sphincter competency and the distance of the rectal foreign body from the anal verge.⁴ Bright red blood in the rectum is often noted but is not always present. Laboratory evaluation is not very helpful in the diagnosis except where perforation is suspected, the white blood cell count may be elevated. Radiologic evaluation is more important than any laboratory test. Antero-posterior and lateral X- rays of the abdomen and pelvis should be done to determine position, size, and shape, of foreign body and to note presence of pneumoperitoneum. When foreign body is absent in the rectal vault rigid proctoscopy or endoscopic evaluation should be done to assess the degree of rectal mucosal injury, visibility of the foreign body and its distance from the anal verge.^{3,4}

After completion of assessment Transanal extraction can be attempted. This is successful in the majority (90%) of cases.⁶ Successful extraction depends on sphincter relaxation. This can be achieved with a spinal anaesthesia, perianal nerve block or general anaesthesia.^{4,5} After the patient has been properly anaesthetized lithotomy position should be given and attempt be made to remove the object. Downward abdominal pressure can be used to aid the extraction of foreign body. The anal canal should then be gently dilated. If the foreign body can be easily palpated, it is amenable to Transanal extraction using various clamps and instruments. In case of fragile items, such as light bulbs and bottles excessive manipulation should be avoided so they do not break

inside the rectum causing further injury to the mucosa. Mucosa of the rectum and colon needs to be properly examined after successful removal of a rectal foreign body.⁷ A rigid or a flexible sigmoidoscopy can be used for this purpose.⁸ Various methods have been described in literature to extract rectal foreign bodies, including Foley catheter, Sengstaken-Blakemore tube, obstetrical forceps and vacuum extractor.⁵ Endoscopy is useful in cases where the foreign body is located high in the rectum or even in colon. If Transanal and endoscopic approaches fail to retrieve the foreign body and if signs of peritonitis are present, the patient needs to be taken for surgery.^{3,4} Lake et al. determined that when the foreign object was in the sigmoid approximately 55% of cases eventually required surgery for removal, as opposed to only 24% in cases of rectal objects.⁹ Some authors have recommended a laparoscopic approach initially to push the foreign body downwards to allow for Transanal removal, specifically if the objects have migrated in to proximal bowel during manipulation and required to be advanced back down into the rectum with gentle transperitoneal pressure.^{3,4} If milking of the object distally into the rectum fails, then a colotomy and removal of the foreign object is needed. This colotomy can be primarily repaired. Diversion is reserved for patients with frank peritonitis, perforation with extensive fecal contamination and unstable patient.^{3,4} Postextraction endoscopy and plain radiographs are a must before discharge to confirm if any injury occurred during the process of extraction. Bleeding from lacerations in the rectal mucosa is generally self-limited. Death from sepsis and multisystem organ failure has been reported.

CONCLUSION

Diagnosis and management of patients with rectal foreign bodies can be challenging. Most of the cases can be successfully managed conservatively. Occasional visit to the operation theatre may be required for laparoscopy or laparotomy assisted extraction.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Irpatgire R, Sarda V, Kale D. Rectal foreign body: case report and review of literature. Int Surg J 2016;3:2334-6.