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Case Report

Unusual foreign body in rectum: a surgical curiosity

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ABSTRACT

Rectal foreign bodies represent a unique and challenging field of surgical management which includes a careful history, physical examination and a high index of suspicion for complications. Foreign bodies are rarely seen in lower GI or rectum, inserted either accidently or for sexual satisfaction or to inflict harm. We have 3 case scenarios of unusual foreign body in rectum with varied clinical presentation, findings and three different methods of management/extraction done in our Institution. Patients present with common complaints of rectal or abdominal pain, constipation or obstipation, bright red blood per rectum, or incontinence. Initial step is to assess for peritonitis which is suggestive a perforation with intraperitoneal contamination and requires emergency exploratory. Erect Xray abdomen can reveal the presence of free air and the location of the object relative to the pelvic floor. A careful digital rectal examination is the most informative component of the evaluation process. Impacted foreign bodies may result in complications like intestinal obstruction, perforation of gut and peritonitis. Rectal foreign body is a diagnostic and management dilemma due to the delayed presentation owing to associated social stigma. Patients require a detailed examination and radiographic evaluation with resuscitation. Surgical intervention should be planned based on hemodynamic stability and presence/absence of perforation. Patient has to be referred to the psychiatrist for his perversion disorder, which is also mandatory for preventing recurrences.

Keywords: Rectal foreign body, Peritonitis, Laparotomy

INTRODUCTION

Rectal foreign bodies represent a challenging and unique field of surgical management. The approach includes a careful history, physical examination and a high index of suspicion for complications.[1] The first described report on the management of retained rectal foreign bodies dates to the 16th century, and the first case reports of the modern era were published in 1919.[1] Foreign bodies are rarely seen in lower GI or rectum, inserted either accidently or for sexual satisfaction or to inflict harm.[2] Various kinds of foreign object may be observed in the rectum, including sharp instruments that may pierce rectum, colon, or create visceral organ injuries. Locating and extracting the item is an emergency procedure that can have serious complications.[2]

In series we have 3 case scenarios of unusual foreign body in rectum with varied clinical presentation, findings and different methods of management/extraction.

CASE REPORT

Case 1

A 45-year-old male presented with history of abdominal pain, bleeding per rectum and insertion of cucumber into the anus. On examination features of generalized peritonitis with diffuse abdominal tenderness and absent bowel sounds were noted. Erect X-ray abdomen showed air under the diaphragm Figure 1. With the suspicion of hollow viscus perforation due to foreign body insertion, patient was taken up for Emergency exploratory

laparotomy, Intra operatively 20 cm long cucumber in the peritoneum with 3 cm anterior perforation in the sigmoid colon and fecal peritonitis was found Figure 2. Primary closure of sigmoid colon perforation with loop ileostomy and extraction of the cucumber was done Figure 3.

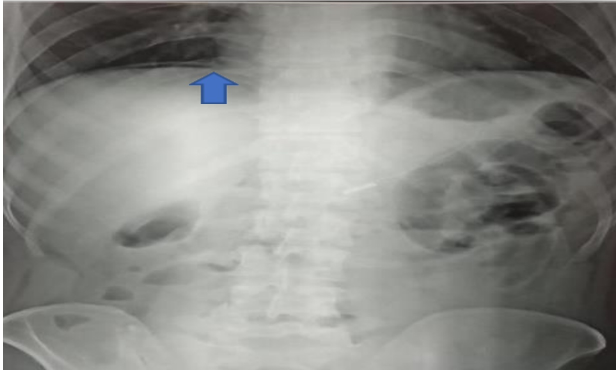

Figure 1: Air under diaphragm.

Figure 2: Perforated sigmoid colon.

Figure 3: Extracted foreign body.

Case 2

A 35-year-old male came with h/o foreign body insertion per rectum. History of similar complaints in the past on 2 occasions associated with auditory hallucinations was noted. Psychiatric evaluation diagnosed him to have multiple personality disorder with features of sexual perversion. Erect X-ray abdomen showed presence of intact foreign in pelvic region. Figure 4 on examination-per rectal examination revealed foreign body (steel pot measuring 10x8 cm) visible per rectum with dilated anal sphincters and mucosal tears. Foreign body was extracted by trans-anal approach under spinal anesthesia (Figure 5).

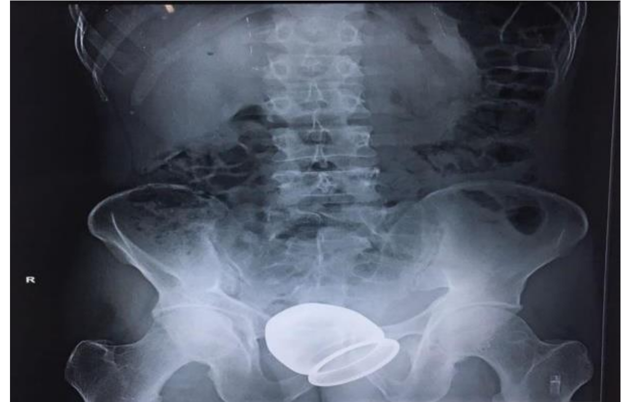

Figure 4: Erect X-ray of steel pot in pelvis.

Figure 5: Extracted steel pot.

Case 3

A 19-year male presented with history of foreign body insertion for sexual gratification. On examination abdomen was soft. Erect X-ray abdomen showed presence of intact deodorant bottle (15 cm) in Figure 6. Patient underwent exploratory laparotomy proceeded with removal of foreign body by downward maneuver and extraction through anus (Figure 7 and 8).

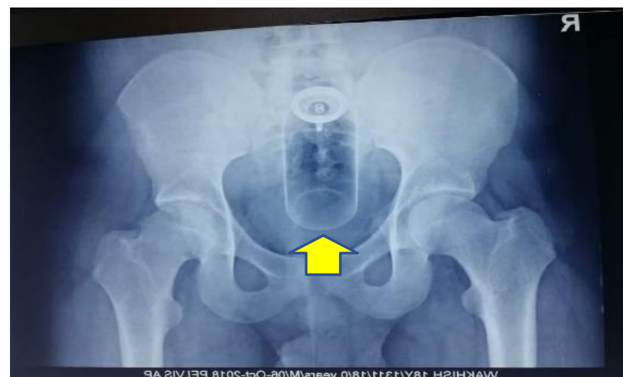

Figure 6: Erect X-ray of deodorant bottle.

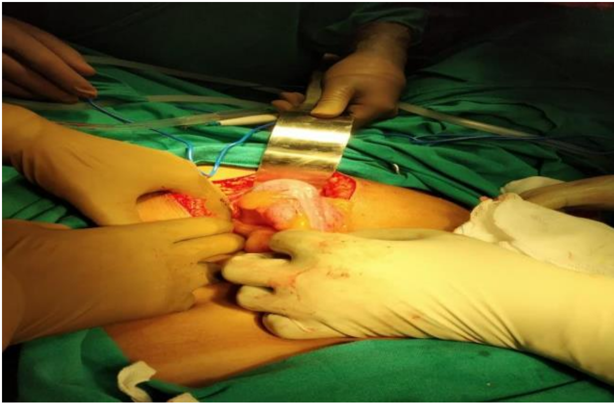

Figure 7: Exploratory laparotomy.

Figure 8: Extracted intact foreign body.

DISCUSSION

In a case of foreign body rectum common complaints include rectal or abdominal pain, constipation or obstipation, bright red blood per rectum, or incontinence.[3] The first step is to assess for peritonitis, which requires emergency laparotomy and suggests a perforation with intraperitoneal contamination. Upright abdominal radiograph can reveal the presence of free air and the location of the object relative to the pelvic floor. A careful digital rectal examination is the most informative component of the evaluation process, indicates the proximity of the object to the pelvic floor.[4] Foreign body may get dislodged into the wider sigmoid colon due to sphincteric spasm and inadvertent manual push during the effort to extract them. Impacted foreign bodies may result in complications like intestinal obstruction, perforation of gut and peritonitis.[5]

CONCLUSION

Rectal foreign body is a diagnostic and management dilemma due to the delayed presentation as they are associated with social stigma. Such patients need detailed examination and radiographic evaluation with resuscitation. In nonperforated stable patient, the foreign body can be removed in the emergency department with a local block and/or sedation via the trans anal approach. If this fails, then the patient has to go to the operating room for a spinal/general anaesthesia and attempted for trans anal extraction. Surgery with laparotomy should be reserved for patients with perforation, ischemic bowel or failed trans anal attempts. Careful observation and follow up needed post operatively. Patient has to be referred to the psychiatrist for his perversion disorder, which is mandatory for preventing future recurrences.

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