Case Report

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Rectal foreign body: a case report

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ABSTRACT

Colorectal foreign bodies are infrequently encounteredand present a dilemma for management. The diagnosis may be confirmedby plain abdominal radiographs and rectal examination, butabdominal computerized tomography with 3-D reconstruction can be decisive in thefurther management and must be advised without reconsideration. Transanal removal is only possible for very low-lying objects, while patients with high-lying foreign bodiesusually require anoperative intervention. An early decision of laparotomy should only be madeafter subjecting the patient to suitable investigations to determine exactly the localization of the object, in order toavoid any inadvertent damage to the adjoining vasculature well as anal incontinence. We report the case of a youngadult male who presented in the emergency department with a Hand Held Bidet Shower inserted per rectum. Transanal removal was unsuccessful and Emergent laparotomy with colotomy and primary repair was necessary for safe removal of the same.

Keywords: Foreign body, Rectal foreign body, Sexual perversions

INTRODUCTION

Intentional or unintentional insertion of rectal foreign body is no longer a medical oddity. It is encountered frequently.¹ Anorectal eroticism with variety of phallic substitutes comprised most of the cases.¹ Rectal foreign body management has always been a challenge to surgeons and various techniques and approaches have been devised to remove these impacted objects.²,³ Reluctance to seek medical help and vague history often makes diagnosis difficult.³,⁴ Patients themselves would have made multiple attempts to remove the foreign body, which often have been proven unsuccessful.⁴

CASE REPORT

In this article, we report the case of a 22-year-old male who had inserted a Hand-Held Bidet Shower into the rectum. He complained of pain in lower abdomen and anal region with no history of bleeding per rectum or urinary symptoms.



Figure 1: Plain X-ray of the abdomen showed a foreign body in the rectum that reached up to the pelvic brim.

On examination, he had lower abdominal distension and increased bowel sounds on auscultation but there were no signs suggestive of peritonitis. On digital rectal examination, anal tone was found to be poor. The severed end of the pipe attached to the end of Bidet shower was palpable per rectally 4cm from anal verge. The upper end of the object could not be felt. There was no active bleeding per rectum.



Figure 2: Superior view of 3D reconstructed CT pelvis.



Figure 3: Inferior view of 3D reconstructed CT pelvis.



Figure 4: 3D reconstructed image of foreign body in rectosigmoid.

The nature and orientation of the foreign body could not be ascertained and hence CT with 3-D reconstruction was done (Figure 2, 3, 4).



Figure 5: Lower midline laparotomy incision showing rectosigmoid containing foreign body.



Figure 6: Incision made on anterior wall of rectosigmoid to extract foreign body.



Figure 7: Hand held bidet shower with 8 cm of hose attached to distal end removed from rectosigmoid.

We were unable to extract the object transanallyunder anaesthesia due to handle of the object which was entangled in the bowel mucosa and the Bidet shower was pushed proximally by the patient in an attempt to extract the Bidet shower. The patient had continued to have lower abdominal discomfort. Consequently, a laparotomy was done (Figure 5) and foreign body retrieved through an incision made on anterior wall of rectosigmoid region

(Figure 6). Hand Held Bidet Shower with 8 cm of hose attached to distal end (Figure 7) was removed carefully without inflicting injury over bowel mucosa. Primary closure of bowel was then performed.

The postoperative period was uneventful. Psychiatric consultation was also arranged for the patient. He was discharged after one week with advice to follow up in Surgery and Psychiatry OPD.

DISCUSSION

It appears through various medical literatures, foreign bodies inserted in the rectum are usually for sexual gratification or non-sexual purposes as is the case of in body packing of illicit drugs.^{4,5} Men have the higher incidence compared to women and the rectum and sigmoid colon are the commonest site for the lower gastrointestinal tract foreign bodies.⁶

A detailed clinical history and physical examination are essential for the diagnosis and management of these patients. The patient may present in varied ways ranging from asymptomatic cases to 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. The most common presentation is complaint of anal pain and bleeding (66.7%) and unsurprisingly a history of anal introduction is present only in 33.3% cases. ^{1,2} 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. 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.

Plain X-rays of abdomen and pelvis is mandatory to determine the presence, number, shape, size, location and direction of foreign body. CT scan must be done to confirm foreign body if X rays cannot reveal it.

Trans anal delivery should only be done under direct vision. Extraction of the foreign body should only be attempted after adequate relaxation of anal sphincter by general or spinal anaesthesia. Hard objects are potentially traumatic and tend to migrate upwards. Abdominal manipulation and stabilisation helps in retrieval when the material is slippery. The anal canal should be dilated gently, and if the foreign body is palpable, it may be grasped and extracted manually, following the rectosigmoid axis. If the foreign body is higher up, the anal canal should be gently dilated with a speculum and the rectum insufflated. 10,11 Sliding a Foley catheter past

the foreign object and inflating the balloon above it may help pull the rectal foreign body toward the anal canal, however, this may not always be feasible if the item is tightly wedged. 12,13

If trans anal and endoscopic approaches fail to retrieve the foreign object or there are peritoneal signs the patient needs to be taken for surgery. Lake et al and Yaman and their colleagues suggested predictors for surgical intervention which respectively included foreign bodies which are larger than 10 cm, hard or sharp, or located in the proximal rectum or distal sigmoid. The first step is to assess the sigmoid distally to rule out transmural injury. Then an attempt to push the foreign body into the rectum for trans anal removal should be tried. If the orientation and shape of the object are unfavorable, a colotomy can be made and the item can be extracted through the peritoneal cavity. Bowel closure can be done primarily.

However, Laparotomy should be considered as primary method of treatment if patient presents with impacted foreign body at a higher level or with signs of peritonitis, perforation or pelvic contamination. In few of these cases, diversion colostomy and reversal after 6 weeks may be deemed necessary.⁸

All patients should also undergo psychological evaluation to avoid similar episodes in the future.

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