Case Report

Rectal foreign body: A case report

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Abstract

Rectal foreign bodies (RFB) present the modern surgeon with a difficult management dilemma, as the type of object, host anatomy, time from insertion, associated injuries and amount of local contamination may vary widely. Reluctance to seek medical help and to provide details about the incident often makes diagnosis difficult. Management of these patients may be challenging, as presentation is usually delayed after multiple attempts at removal by the patients themselves have proven unsuccessful. In this article we report the case of a male who presented with a large cylindrical plastic handle of broom inserted into his rectum. As he was unable to extract the object, we under light sedation (↓ GA) extracted the object through transanal rout. Foreign bodies in the rectum should be managed in a well organized manner. The diagnosis is confirmed by rectal examination, plain abdominal radiographs and CT scan. Manual extraction with light sedation is possible for very low lying objects. Management of patients with rectal foreign bodies can be challenging. The majority of cases can be successfully managed conservatively, but occasional surgical intervention is warranted.
Keywords: Foreign body, Rectum, Surgical intervention.

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INTRODUCTION

Foreign body insertion in the rectum has been extensively described in the surgical literature, with the earliest reports dating back to the 16th century. Retained rectal foreign body (RFB) is no longer a medical oddity, it is encountered frequently[1]. Anorectal eroticism with a wide variety of phallic substitutes comprised most of the cases[2]. A problem commonly encountered in patients with RFB is the delay in presentation[3,4]. It is important for emergency room physicians and general surgeons to be systematic in their approach and be familiar with a variety of extraction techniques and management of colorectal injuries resulting from the insertion or extraction of the foreign body.

CASE PRESENTATION

A 30-year-old male presented to the emergency department (ED) complaining of mild pelvic pain from a large cylindrical-shaped plastic handle of broom, he had inserted in his rectum approximately 6 h prior to presentation. The patient reported that multiple attempts to remove it at home failed, prior to his arrival at the ED. On examination, his vitals were within normal limit. His abdomen was non-distended, soft, non-tender, without signs of peritonitis. Bowel sounds were mildly exaggerated. On per rectal examination sharp circular open end of plastic handle of broom was felt at lower rectum, impacted at ano-rectal junction. Thus finger could not be passed between foreign body and the rectal mucosa. So it could not be manually extracted. X-ray of abdomen AP view was within normal limit without clear impression of foreign body. CECT abdomen and pelvis revealed a large, cylindrical-shaped object in the rectum extending from lower rectum to sigmoid colon in the direction of right iliac fossa **(Fig. 1).** After fluid resuscitation and preoperative intravenous antibiotics, the patient was brought to the operating room, where he was given light sedation (↓ GA) and placed in lithotomy position. We attempted to remove the foreign body with lubrication and use of sponge holding forceps which was successful. The specimen, a cylindrical plastic broom handle measuring 18 cm × 3cm × 3 cm, as in **(Fig. 2)** was retrieved. Sigmoidoscopy was done and revealed minor

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mucosal erosions near ano-rectal junction because of impaction of object and manipulation during retrieval. As the proximal end of the foreign body was smooth there was no bowel injury or perforation. The patient had an unremarkable recovery and was discharged on same day after normal sigmoidoscopy.

Figure 1

Figure 2

DISCUSSION

The incidence of rectal foreign bodies is more in urban populations[3]. Although the medical literature is replete with numerous case reports and case series of RFB in patients of all ages, genders and ethnicities[1], the majority are male in their 3rd and 4th decades[3,4,5]. Foreign bodies can be inserted in to the rectum for sexual gratification or non-sexual purposes – as is the case in body packing of illicit drugs[6] and voluntarily or involuntary. Numerous types of objects have been described in the literature (ranging from fruits and vegetables[7], cosmetic containers, cans or bottles, batteries, light bulbs and sex toys) and all of them should be regarded as potentially hazardous of causing significant injury. More often than not, patients who present to the emergency department with RFB have attempted to remove the object unsuccessfully prior to seeking medical care[1]. Pelvic or even abdominal pain, if perforation has occurred above the peritoneal reflection, bleeding per rectum, rectal mucous drainage, even incontinence or bowel obstruction can be the presenting symptoms. One should always bear in mind that individuals with RFB may be reluctant to reveal the true reason for their ED visit and may have delayed presentation for many hours, even days, in hope of spontaneous foreign body passage. It is important to maintain a high degree of suspicion should someone present with the afore mentioned symptomatology. Physical examination is centered on ruling out peritonitis. A rectal examination should be performed, to assess the distance of the RFB from the anal verge and to determine sphincter competency. It is uncommon for the sphincter to have been injured in cases of voluntary insertion. Routine laboratories are recommended to assess the extent of physiologic derangement from the presence of the RFB. An abdominal series would define the nature, size and shape of the foreign body, its location, and rule out sub diaphragmatic free air. Computed tomography of the abdomen and pelvis may be considered if the RFB has been in place for more than 24 h. Once work up is complete, rigid proctoscopy should be undertaken – especially for foreign bodies high up in the rectum, when digital examination is insufficient – to assess the degree of rectal mucosal injury, visibility of the foreign body and its distance from the anal verge. Care should be taken to prevent further pushing the rectal body higher up in the recto-sigmoid. Abdominal X-ray imaging and endoscopic surveillance of the colonic mucosa immediately after RFB removal is mandated to rule out inadvertent extraction-related injury and perforation[1,3]. Even if transanal extraction was performed without difficulty, close observation for many hours with serial abdominal examinations is recommended[3]. If celiotomy was undertaken, endoscopy should ideally be performed prior to closure. Continuing resuscitation and observation, postoperative pain control, early ambulation and diet initiation upon return of bowel function should follow guidelines of any general surgical intervention. Extrapolating from the trauma literature, antibiotics should not be continued past 24 h, in early presenters with no evidence of abdominal sepsis. In cases of sexual assault, long-term psychological consequences may occur, and early involvement of a mental health provider

is warranted.[3] Discharge should be considered when bowel physiology returns. If there is evidence of sphincteric injury, attempt at surgical correction should be delayed.

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