Foreign body rectum: A case report

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ABSTRACT

Rectal foreign bodies are confronted frequently in a surgical emergency. These are often related to sexual behaviour. Due to the fear of social embarrassment, patients tend to hide the facts associated with the incident and present late. Because of the serious complications, foreign body rectum should be considered as an emergency and managed in a well-organised manner. Diagnosis can be made by clinical and radiological examination. In the majority of cases, the transanal approach is successful. Laparotomy is reserved for cases with perforation or peritonitis. Here, we report the case of a 24-year-old male who inserted an electrical beard trimmer in his rectum under alcohol intoxication. Since transanal removal failed, emergency laparotomy with successful removal of foreign body was done.

Keywords: *Peritonitis, Rigid sigmoidoscopy, Sexual behaviour, Laparotomy.*

Rectal foreign body is common these days, patients with the intentional or unintentional insertion of the foreign body are encountered frequently inthe emergency room (ER). In adultsin the majority of cases, homosexual practices and auto-eroticism is the main cause [1]. However,the rectal foreign body may be an ingested one which is impacted at the rectum. This has been encountered more often in children with mental disabilities. Although there are various techniques and approaches available for removal, management of such patients is challenging as patients usually present late with multiple unsuccessful attempts to remove the foreign body themselves. In addition, patients often fail to provide a proper history of the event [2].

We report the case of a 24-year-old male who inserted an electrical beard trimmer in his rectum under alcohol intoxication. With the increasing use of different designed and improvised objects for sexual arousal, the clinicians must be well informed about the approach to the management of the patients with foreign bodies retained in the rectum.

CASE REPORT

A 24-year-old male presented in the ERwith complaint of pain in the lower abdomen and anal region for 4 hours. There were no symptoms of vomiting, distension of abdomen, bleeding per rectum or any urinary symptoms.The patient had a history of alcohol intoxication on that day.

On examination, his blood pressure was 100/60 mm Hg, pulse was 110 beats per minute, and oxygen saturation was 98%.On palpation, the abdomen was soft,non-tender with no signs of peritonitis. On per rectal digital examination, the anal tone was found to be normal and no active bleeding was present. Since the patient was an alcoholic, we suspected the presence of some foreign body inserted through the rectum by the patient.

Radiograph of the abdomen supine postero-anterior (PA) view and the lateral view was performed (Fig. 1). An X-ray revealed the presence of a foreign body in the recto-sigmoid region. On further coaxing, the patient admitted inserting an electrical beard trimmer into his rectum for sexual gratification.

The patient was shifted to the operating room. Under general anaesthesia and in the lithotomy position, foreign body removal was attempted through the anal route using forceps. Since the foreign body was higher up and impacted, our attempt failed. Consequently, laparotomywas proceeded and foreign body

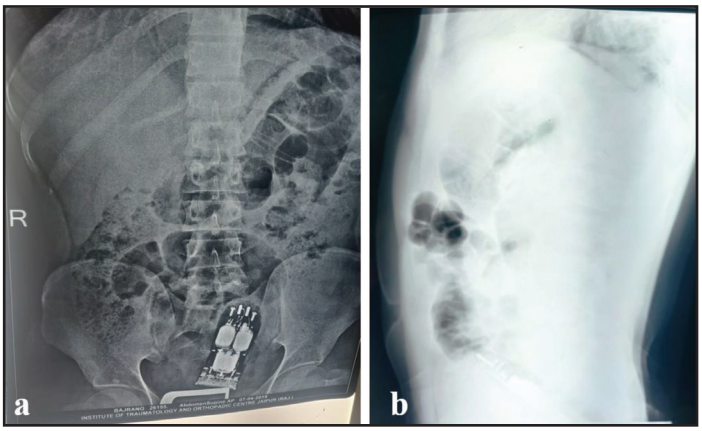

Figure 1: X-Ray abdomen (a) postero-anterior and (b) lateral view showing the presence of a foreign body in the rectum.

Figure 2: A 10 cm long electric trimmer was removed from recto-sigmoid.

retrieved by manual propulsion towards the anus. A 10 cm long electrical trimmer (Fig. 2) was removed carefully without inflicting injury to bowel mucosa.

Check colonoscopy was done to rule out any mucosal injury in the rectum or sigmoid colon. There was no sign of any injury or perforation.Primary closure of the abdominal wall was then performed.The patient was started on intravenous Ceftriaxone for 5days. The postoperative period was uneventful. Psychiatric consultation was also arranged for the patient. He was discharged after 4 days. On follow up after 1 week, the incision site was healed, with no signs and symptoms of postoperative complications. The patient was referred to the Psychiatrydepartment for further management.

DISCUSSION

Rectal foreign bodies are more common in the age group of 30-40 years, with males having a higher incidence than females [3,4]. A systemic review of 193 patients of rectal foreign body conducted by Kurer etal.found a male:female ratio of 37:1 regarding the incidence of the rectal foreign body. Also mean age was found to be 44.1 years [4].

Variety of rectal foreign bodies are described in literature like, plastic or glass bottles, cucumbers, carrots, wooden, or rubber objects, bulb, tube light, axe handle, broomstick, vibrators, dildos, utensils, Christmas ornaments, broken enema catheters, thermometers, ingested fish bone and prosthetic teeth [3,5,6]. Rectal foreign bodies can be categorised either as voluntary versus involuntary or sexual versus non-sexual. Body packing for drug trafficking is a common type of non-sexual rectal foreign body [3].

Case presentations may range from asymptomatic to peritonitis which depends upon the type of foreign body, mode of insertion, duration and failed attempts to extract the foreign body. Most common complaints are lower abdominal pain and bleeding per rectum [6]. For diagnosis of these patients, a detailed history and physical examination including careful abdominal examination to rule out signs of peritonitis should be conducted. Rectal examination is the essential part of the diagnosis but it is recommended to be performed after X-ray to avoid any accidental injury to the surgeon from sharp objects [7]. Radiological investigations should include a plain X-ray abdomen in PA and lateral view, to determine the location, number, size and shape of the foreign body and presence of pneumoperitoneum. Computed tomography(CT) scan should be reserved for the complicated cases with suspected sepsis or peritonitis [8]. In our case,the patient came to ERunder alcohol intoxication and lower abdominal pain. He didnot give any history of the presence of the foreign body in his rectum. For further evaluation, plain X-ray abdomen was done, in which foreign body in his rectosigmoid region was found.

Patients with a foreign body often develop spasm or edema. For transanal extraction adequate relaxation of anal sphincter by general or spinal anaesthesia is required andthe patient should be placed in lithotomy position to facilitate direct visualisation [3,9]. If the foreign body is not palpable inthe suprapubic region, sigmoid pressure can be applied to move object caudally and then it can be removed with the help of forceps. Sharp objects are a threat to both patient and surgeon. These should not be removed transanally. A rigid or flexible endoscope can be used for their removal.Smooth objects sometimes createa vacuum in the rectal vault. Extraction of such objects can be facilitated with the help of Foley's catheter. Use of Sangstaken Blackmore tube has also been recommended for removal of the foreign body [9,10,11]. Endoscopic extraction with the help of rigid or flexible sigmoidoscopy is reserved for the objects located more proximally in the rectum [11]. In case of failure to remove foreign body using the above techniques, laparotomy has been recommended with the milking of the foreign body towards anus [9]. Laparoscopic removal of the foreign body has been described by Bak et al [12].In cases with ingestion of illicit drugs, drug packets should be removed with a digital rectal examination, as clamps or graspers may rupture these packets. If signs and symptoms of peritonitis or drug toxicity are present, exploratory laparotomy is indicated [13].

If these methods fail, or the patient develops perforation or peritonitis, laparotomy should be done to retrieve the object and repair the tissue damage [14]. All patients should be observed closely for any injury or perforation that might have occurred during the process of extraction. Psychiatric consultation should be arranged for all patients to prevent similar episodes in the future.

CONCLUSION

Due to embarrassment and shame associated with the condition, maintaining the privacy of the patient is of utmost importance. The patient should not be a topic of humour for the caregivers. A surgeon should make every possible attempt to take the patient into confidence and extract accurate history. After thoroughly assessing the patient, the appropriate technique should be uses for the removal of the foreign body. Psychological evaluation of the patients should be done to avoid future incidents.

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