
CASE REPORT

RECTAL FOREIGN BODY: NOT A RARITY

Jan Muhammad Memon, Nazar Ali Memon, Mohan Khataomal Khatri, Altaf Ahmad Talpur,
Abdul Ghaffar Ansari, Abdul Hakim Jamali, Ali Akbar Ghumro

Department of Surgery, Nawabshah Medical College, Nawabshah, Pakistan

ABSTRACT

Rectal foreign body is no longer a medical oddity. The majority of objects are inserted by self introduction in children, psychiatric patients, in victim of assault and as a result of sexual gratification. It causes lower abdominal pain and rectal bleeding. The presence of a foreign body in the rectum has always been a challenge and numerous approaches have been devised for its recovery. Before manipulation of a foreign body, rectal perforation and peritonitis must be ruled out. Laparotomy is sometimes necessary. We report a case study of a rare foreign body in the rectum with unusual presentation.

Key words: Rectum, Foreign Body, Laparotomy.

INTRODUCTION

Rectal foreign body is no longer a medical oddity, it encounters frequently.^{1,2,3} The majority of objects (fruits, vegetables, bottles, vibrators, candles and dildos) are inserted by self introduction in children, psychiatric patients, in victims of assault and as a result of sexual gratification.⁴ It causes lower abdominal pain, rectal bleeding and becomes irretrievable. Sometimes the patient will not volunteer that any object has been inserted or give outlandish explanations. The presence of such foreign body has always been a challenge to the physicians taking care of these patients and numerous approaches have been devised to recover these objects. Before manipulation of a foreign body rectal perforation and peritonitis must be ruled out. If insurmountable difficulty is experienced for any foreign body in the rectum, a laparotomy is usually necessary, which allows that object to be pushed from above into the assistant's finger in the rectum.⁵

We report a case of a foreign body in the rectum with its rarity and unusual presentation.

CASE REPORT

A 45 year old married male presented to the Department of Surgery, Nawabshah Medical College Nawabshah, Pakistan, as a victim of assault with three days history of foreign body insertion in the rectum. He was illiterate and belonged to non-affluent group. The presenting complaints were lower abdominal pain and slight bleeding per rectum. He was embarrassed, apprehensive, uncomfortable and un-cooperative. The signs and symptoms of mechanical intestinal obstruction and colorectal perforation were absent. He had at-

tempted to retrieve the foreign body himself but failed, which resulted in its movement of foreign body high up. Rectal examination revealed perianal bruises, impacted foreign body approximately 11 cm above the anal verge and a blood stained finger. Abdominal examination was unremarkable. Abdominal radiograph revealed a glass bottle in the upper rectum. (Fig-1)



Fig. 1: Plain x-ray abdomen showing glass bottle in the pelvis

Before manipulation rectal perforation and peritonitis were clinically ruled out. In the emergency room a female surgeon inserted her hand trans-anally to grasp the object with her fingers but was unable to mobilize it distally. Laparotomy was performed for transabdominal manipulation and transanal retrieval under general anaesthesia with full sphincter relaxation. The patient was placed in lithotomy position and after exploration by lower midline laparotomy incision foreign body (glass bottle) was pushed distally and retrieved trans-anally. (Fig-2) The size of the glass bottle was 4x20 cm. (Fig-3)



Fig. 2: Trans-anal retrieval of glass bottle after trans-abdominal manipulation by laparotomy.



Fig. 3: Showing retrieved glass bottle 4x20 cm.

His post-operative period was uneventful. He resumed his oral intake after 18 hours and was discharged after 72 hours with judicious follow up. Sphincter integrity was assessed and he was found to be continent.

DISCUSSION

Rectal foreign bodies, once a medical curiosity become much more common in certain settings.⁶ They may be high or low lying but the management is a more challenging problem. Transanal delivery should only be done under direct vision.⁷ Entire hand could be inserted under general anaesthesia to retrieve foreign body as long as it is lying low in the rectum.⁸ Laparotomy should be considered as primary method of treatment if the patient presents with a high lying foreign body impacted for 24 hours or longer.⁹ The possibility of rectal perforation must be taken into account especially with long standing foreign bodies that can erode the bowel wall. It is evident that the clinical history given for sexually related injuries are often vague and non specific because of embarrassment and fear of humiliation. A cautious anorectal examination not only allowed palpation of the low lying object but also helps to disclose the possible complications caused by foreign body. The presence of tarry mucoid rectal discharge with a necrotic odor raises the suspicion of gangrene of rectum. A careful abdominal examination should also be performed to assess signs of peritonitis or the ability to palpate the object in the abdomen. Bipolar roentograms of abdomen and pelvis are required to determine the presence, number, size, shape, location and direction of foreign body. This information is paramount in planning the extraction maneuver.

Different strategies for safe removal are required after adequate relaxation of anal sphincter. Anoscopy or sigmoidoscopy should be utilized to remove the foreign body under direct vision to avoid injury. Foreign bodies made of glass require special attention for that the object should be removed intact with out breaking it. Insertion of Foleys catheter around the object, inflating its balloon and applying traction on catheter will help to remove the object.¹⁰ For the objects that are not fragile, obstetric forceps provides considerable success rate.

All the patients are referred for psychological evaluation to avoid similar problem in future and to minimize the psychological trauma to patients in assault cases.

CONCLUSION

Foreign body in rectum presents a management problem. Uncomplicated foreign bodies

can be simply extracted in the operating room with adequate anesthesia and muscle relaxation. Open surgery should be reserved only for those patients with overt peritonitis or pelvic sepsis.

REFERENCES

1. Bush DB, Starling JR. Rectal foreign bodies case reports and comprehensive review of the world's literature. *Surgery* 1986; 100: 512-9.
2. Kouraklis G, Misiakos E, Dovas N, Karatzas G, Gogas J. Management of foreign bodies in rectum, report of 21 cases. *JR Coll Surg Edinb* 1947; 42: 246-7.
3. Ooi BS, Ho YH, Eu KW, Nyam D, Leong A, Seow – Choen F. Management of anorectal foreign body: a cause of obscure anal pain. *Aust NZ Surg*. 1998; 68: 852-5.
4. Couch CH, Tan EGC, Watt A AG. Rectal foreign bodies. *Med J Aust* 1986; 144: 512-15.
5. Russel R.C.G, Norman S. Williams. Cristopher J.K. Bulstrode. *Bailey & Love's Short Practice of Surgery*. 24th (Ed) 2004; Vol 02; pp. 1223.
6. William P.Schechter, Robert J .Albo. Removal of rectal foreign body. *Mastery of Surgery (Ed)3rd*; 1996, Vol 2; pp: 1555-59.
7. Eflaiha M, Hambrick E, Abcarin H. Principles of management of colorectal foreign bodies. *Arch Surg*. 1977; 112: 691-5.
8. Cross R, Tranbaugh R, Kudsk K, Trunkey D. Colorectal foreign bodies and perforation. *Am J Surg*. 1981; 142: 85-8.
9. Kingsley A, Abcarian H. Colorectal foreign bodies management update. *Dis Colon and rectum* 1985; 28: 94-104.
10. Ahmed A, Cummings S, Novel endoscopic approach for free removal of a rectal foreign body. *Gastrointestinal Endoscopy* 1999; 50: 872-4.

Address for Correspondence:

Dr. Jan Muhammad Memon
Assistant Professor Surgery
Peoples Medical College
Nawabshah
E-mail: surgeon_jm_memon@yahoo.com