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Removal of a sex toy under general anaesthesia using a bimanual-technique and Magill's forceps: A case report

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ABSTRACT

INTRODUCTION: Phallic objects may cause large bowel obstruction if not promptly removed. A bi-manual technique with the aid of a Magill's forceps is presented here.
PRESENTATION OF CASE: A 68-year-old man presented to the emergency department with severe lower abdominal discomfort, distension and inability to pass urine, flatus or bowel motions. He had inserted a phallic object in the rectum 10 hours prior to presentation and had been unable to remove same. Abdominal examination was remarkable for distension with tenderness also elicited suprapubically and in the left iliac fossa. The foreign body was barely palpable per rectum. Plain radiographs showed prominent left-sided colonic segments. Following the trial of a manual attempt at removal in the emergency department, a decision was made to remove this under anaesthesia due to worsening symptoms. The phallic object was successfully removed under general anaesthesia using bi-manual manipulation assisted by a pair of Magill's forceps.
DISCUSSION: The method of removal of phallic objects varies from one individual case to another. In the presence of obstruction, a quick decision must be made for removal under general anaesthesia and the patient will also need to be consented for laparotomy. Previous literature described a "cork-in-bottle" technique using myomectomy screws as well as use of single-incision laparoscopic surgery (SILS) ports for removal of phallic objects.
CONCLUSION: Extraction of phallic objects requires ingenuity. We describe another minimally invasive technique of removal that adds to the literature, thereby limiting the need for laparotomy and open removal of foreign bodies.

1. Introduction

The introduction of foreign bodies through the anus may lead to large bowel obstruction if not promptly removed. Numerous objects including bottles, light bulbs, apples, rubber balls, spray containers, vibrators, and other phallic objects have been described [1,2]. Bi-manual manipulation under general anaesthesia is the mainstay of removal of such objects, although some authors advocate the use of polypectomy snares, obstetric forceps, achalasia balloons and even single-incision laparoscopic surgery (SILS) port technique for difficult cases [2–5].

We present a case in which a retained sex-toy causing an imminent obstruction was successfully removed using both a Magill's forceps and bi-manual manipulation technique under general anesthesia.

2. Presentation of case

A 68-year old presented to our institution in December 2014 with a retained sex-toy. The object had been inserted 10 h prior to presentation for erotic stimulation and could not be removed afterwards. He reported a progressive lower abdominal discomfort, distension and inability to pass urine, flatus or bowel motions. In 2006, he had presented with lower back pain following insertion of a foreign object into the rectum. This was successfully removed under sedation by bi-manual manipulation.

His abdominal examination revealed distension and tenderness suprapubically and in the left iliac fossa. The foreign body was barely palpable per rectum with the tip of the examining finger. Plain radiographs illustrated a 23 cm high density ovoid foreign body within the middle of the pelvis and prominent left-sided colonic segments (Fig. 1). There were no clinical signs of rectal perforation.

Attempted removal under sedation in the emergency department was unsuccessful. Therefore, it was necessary to remove the object using a bi-manual technique in the lithotomy position under

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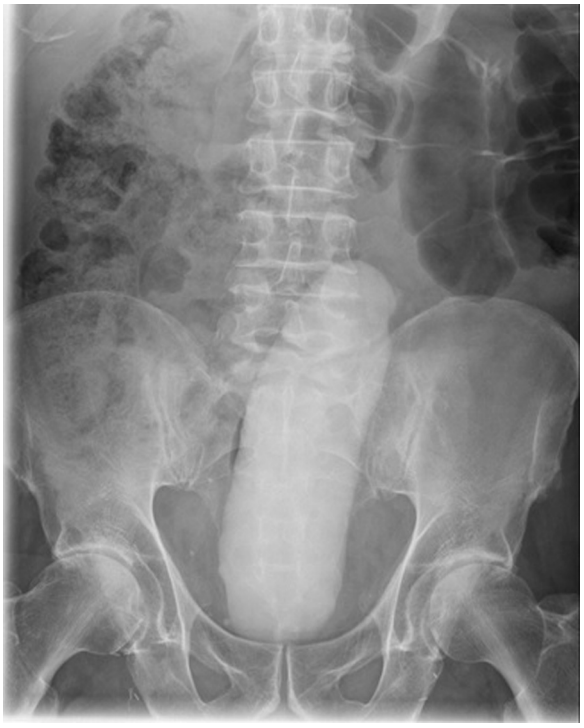

Fig. 1. Plain radiograph demonstrating rectal foreign body.

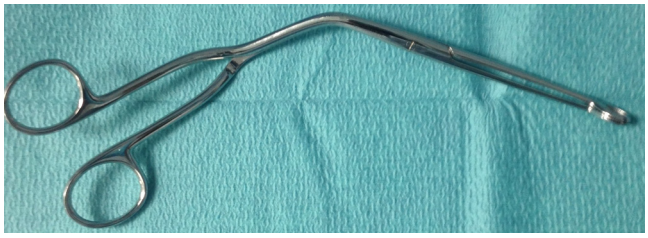

Fig. 2. Magill's forceps.

general anaesthesia in the operating theatre. The phallic object was just palpable in the mid-rectum making bi-manual attempts difficult. Using a Magill's forceps (Fig. 2), under proctoscopic vision, the tip of the object was secured and subsequently removed with the addition of bi-manual technique. Sigmoidoscopy post procedure showed no obvious tears or bleed points. The patient was counselled and discharged the next morning on simple analgesia.

3. Discussion

Rectal foreign bodies present to the modern surgeon with a challenging management dilemma, as the type of object, host anatomy, time from insertion, associated injuries and amount of local contamination may vary widely [3,6].

Prompt removal of anorectal foreign bodies minimises the risk of complications and requirement for laparotomy. Cohen et al [7], in a series of 48 patients reported successful extraction in the emergency department in 31 (63%) patients and operating room extraction in 18 (37%) patients. Of the latter 18 cases, 12 cases were simply extracted under anaesthesia, five patients required primary repair and diverting colostomy for rectal perforation and one required primary repair of an external anal sphincter laceration. In another series of 30 patients, a higher incidence of 7/30 (23%) patients undergoing laparotomy for removal of the foreign bodies was reported [8].

Instrumentation under anaesthesia is generally not regarded as the technique of first choice as forceps can be very traumatic per anum. The use of a proctoscope may enable direct visualisation of the object and minimises the risk of harm, but this may limit free descent of the foreign body. The presence of the proctoscope in this case limited complete free descent of the foreign object during further manipulation and it had to be removed before the successful retrieval of the object. We found that the Magill's forceps was a useful instrument to aid anal manipulation of the foreign body in a difficult case which might have otherwise resulted in a laparotomy [6]. This approach is similar to a previously documented "Cork in bottle technique" for removal of phallic objects [9]. Grasping the objects directly with forceps alone did not work but successful outcome was achieved under general anaesthesia by abdominal and forceps-assisted anal manipulation at the same time. Proctosigmoidoscopy is recommended following retrieval to assess for any residual damage [10,11].

4. Conclusion

Extraction of rectal foreign bodies requires ingenuity. With emerging new techniques, laparotomy for removal of rectal foreign bodies will continue to decline. General anaesthesia for muscle relaxation remains the mainstay of removal of such objects with bi-manual manipulation.

Conflict of interest

The authors have no conflicts of interest to disclose.

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Ethical Approval

An ethical approval was not required.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

Author contribution

Maurice Stokes conceived the initial idea of the study. Obinna Obinwa, Ian Robertson and Maurice Stokes acquired the data for publication, drafted the article and revised it critically for important intellectual content. All authors approved the final version of the manuscript to be submitted.

Guarantor

Mr Maurice Stokes.

Submission declaration

The authors declare: that the work described has not been published previously, that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere

Contributors

MS conceived the initial idea of the study. OO, IR and MS acquired the data for publication, drafted the article and revised it critically for important intellectual content. All authors approved the final version of the manuscript to be submitted.

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