

Foreign body in the rectum: A challenge for the emergency physician

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ABSTRACT

Foreign body (FB) within the rectum occurs infrequently and its management is challenging for the emergency physicians due to variation in type of objects, host anatomy, time of insertion, and amount of local contamination. Usually, the presentation is late after multiple unsuccessful attempts for the removal of the FB by patients themselves at home. We report a 50-year-old male patient presented to the emergency department with an FB in the rectum (iron rod) introduced as sexual perversion. The patient was managed conservatively and transanal retrieval of FB was carried out successfully. We reviewed the management options from the currently available literature.

Keywords: Management, rectal foreign body, transanal retrieval

Introduction

The incidence of rectal foreign bodies (RFBs) is unknown. FB insertion in the rectum has been sporadically described in the surgical literature, with the earliest reports dating back to the 16th century.^[1] RFBs present a challenge to clinical management and known for potential complications. Whether done for purposes of sexual gratification or not, voluntarily or accidentally, the reported incidence of RFBs is rather rare with only isolated published case reports or case series. The incidence of RFB is rising because of increasing use of different object for anal sex.^[2] Most of the objects are introduced through anus; however, sometimes, an FB is swallowed, passed through the gastrointestinal track, and held up in the rectum.^[3] We present a 50-year-old male who inserted an FB rectally for self-satisfaction.

Case Report

A 50-year-old male presented to the emergency room with the history of introducing an iron rod 6 h earlier as a part of sexual perversion. The failure of repeated attempts of self-removal

brought the patient to the hospital. He gave the history of using similar objects for sexual gratification in the past. Vital signs were normal. Abdomen was soft. FB was not palpable per abdomen. X-ray of the abdomen showed the iron rod in the lower abdomen and pelvis [Figure 1].

Perrectal examination performed after the X-ray of the abdomen revealed the base of the iron rod. The manual removal was impossible due to mucous coating the surface. After reassurance and intravenous analgesic, in lithotomy position, the patient was encouraged to bear down as if he pushed the feces. As the bottom of iron rod showed up at anal verge, it was grasped manually and removed with gentle traction [Figure 2].

Postremoval per rectal examination did not reveal any colorectal injury, except some minor anal tears. Postremoval recovery was uneventful. He was referred for psychiatric treatment for his perversion disorder.

Discussion

RFBs, even though rather infrequent, are no longer considered as rare presentation in emergency departments and their incidence

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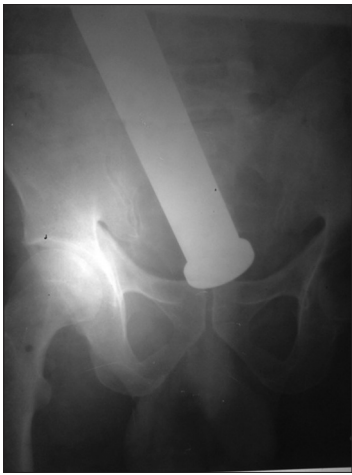


Figure 1: The rod-shaped object as seen on the abdominal X-ray

is increasing, specifically in urban populations.^[4,5] Reports of FB within the rectum are uncommon in Asia. Majority of case series are reported from Eastern Europe.^[6-11] Males are commonly affected.^[6,7] The FBs commonly reported were plastic or glass bottles, cucumbers, carrots, wooden, or rubber objects.^[7] The object length varied between 6 and 15 cm, and larger objects were more prone to complications.^[7]

Vague abdominal pain, rectal bleeding or pain, and sometimes constipation are the common presenting symptoms. Signs of infection or perforation may be present in complicated cases. Careful abdominal examination should be done to rule out peritonitis. Perrectal examination is the cornerstone of the diagnosis, but it should be performed after X-ray of the abdomen to prevent accidental injury to the emergency physician from sharp objects.^[10] Laboratory evaluations are not very helpful in the patient with RFB. If the patient has a suspected perforation, the white blood cell count may be increased along with acidosis. Radiological evaluation is far more important than any laboratory test. X-rays of the pelvis and abdomen help in locating the FB position and to rule out intestinal perforation. Computed tomography of the abdomen and pelvis may be considered if the RFB has been in place for more than 24 h.

Majority (90%) of the cases are treated by transanal retrieval.^[6,7,11,12] Transanal removal should be under direct vision. Hard objects are potentially traumatic and tend to migrate upward.^[13] Colonoscopy removal is also reported with good success.^[8] However, limited studies in literature restrict the major role of colonoscopy. Laparotomy is only required in impacted FB and/or with perforation peritonitis. Even with laparotomy, the aim is transanal removal and closure of perforation with diversion colostomy. Postretrieval colonoscopy and X-ray are mandatory to rule out colorectal injury.

Conclusion

A systematic approach for the management of RFB is proposed to avoid pitfalls. Minimal invasive technique should be preferred;



Figure 2: Extracted iron rod

however, when these techniques are not available or cannot extract the FB, surgery is required. High degree of suspicion is required for someone presenting with aforementioned symptomatology. Perrectal examination is the cornerstone of the diagnosis, but it should be performed after X-ray of the abdomen to prevent accidental injury to the surgeon from sharp objects. Postretrieval colonoscopy and X-ray are mandatory to rule out colorectal injury.

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Conflicts of interest

There are no conflicts of interest.

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