


CLINICAL IMAGE

A rare case of rectal perforation from an accidentally swallowed foreign body

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Funding Information

No sources of funding were declared for this study.

Received: 16 August 2017; Revised: 17 October 2017; Accepted: 5 December 2017

Clinical Case Reports 2018; 6(5): 963–964

doi: 10.1002/ccr3.1359

A 29-year-old man underwent a diagnostic laparoscopy for presumed appendicitis. There was purulent pelvic fluid, no fecal soilage, and the patient was hemodynamically stable (see Figs 1 and 2).

These images demonstrate the rare complication of rectal perforation from an accidentally swallowed foreign body (part of a cocktail skewer), which occurred approximately 48–72 h prior to surgery.

The patient reported dull nonspecific central pain noticed a few hours after ingestion that steadily progressed in intensity. It had localized to the suprapubic region and right iliac fossa by the time he presented to hospital. The pain was associated with nausea, anorexia, and urinary urgency. His mental state was sound at the time he swallowed the object. Clinically, he was afebrile, hemodynamically stable, and demonstrated suprapubic and right iliac fossa tenderness. Inflammatory markers were raised (WCC 13.8; CRP 44), and urine dipstick was clear. A working diagnosis of appendicitis was made and a laparoscopy planned.

Laparoscopy revealed a perforation involving the antimesenteric aspect of the upper rectum just above the peritoneal reflection. This was converted to a formal

Key Clinical Message

Rectal foreign bodies are not an infrequent presentation and can cause a serious dilemma regarding extraction and management. Management is determined by the site of the injury, degree of fecal contamination, the hemodynamic status of the patient, and comorbidities. Intraperitoneal injuries require surgery in the form of either a primary repair or formal resection with or without diversion. Extraperitoneal perforations maybe managed with presacral drainage and antibiotics with or without diversion.

Keywords

Ingested foreign body, rectal perforation.

laparotomy to exclude other hollow viscus or solid organ injuries. Given the early presentation, the clinical stability of the patient, the absence of fecal contamination, and

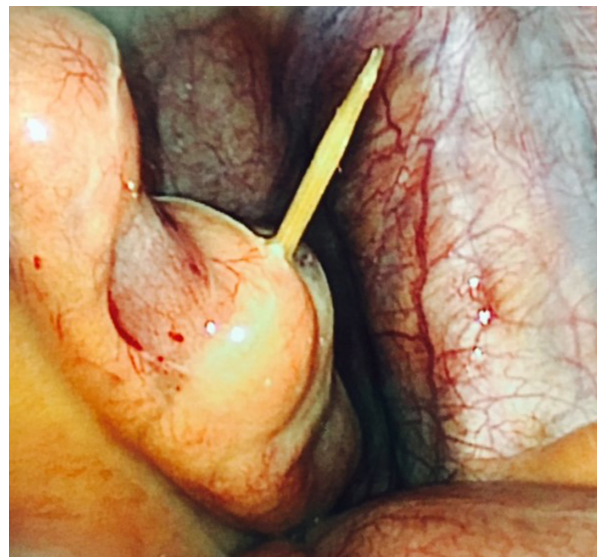


Figure 1. Laparoscopic view of upper rectum.

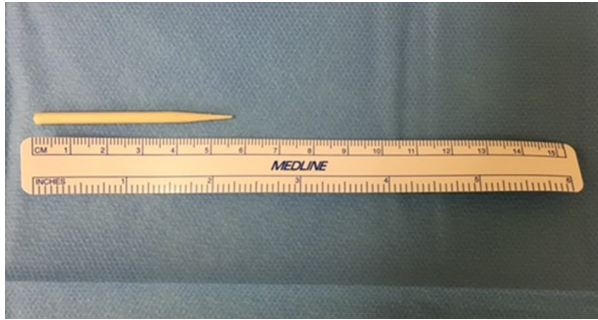


Figure 2. Rectal foreign body (part of cocktail skewer).

minimal tissue damage, the foreign body was removed, devitalized rectal tissue debrided, and the defect repaired without diversion. The patient made an uncomplicated postoperative recovery. He was discharged on day 4 at which point he had resumed a full ward diet and regained normal bowel function. He was clinically well at follow-up 6 weeks postoperatively.

In delayed presentations, unstable patients, those with multiple comorbidities, and/or the presence of significant tissue damage or contamination, diversion with or without a more formal resection maybe be warranted [1, 2].

Authorship

LAS, and CR: conceived, designed and revised the manuscript on numerous occasions, and approved the final version.

Conflict of Interest

None declared.

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