

LETTER TO THE EDITOR**Perianal injury with rebar**

Dear Editors,

Perianal injuries are uncommon but often occur following trauma, fire, and accidents. These injuries usually lead to a rectal injury. We report an interesting case of a perianal injury by a rebar that did not cause a rectal injury. The present case had a unique set of challenges for physicians and led to experience with wound management.

A 33-year-old man presented to the emergency room with a perianal injury that occurred 1 hour earlier. The man fell from the third floor of a work site and was impaled on a rebar. Workmates found the man and cut the rebar at the base. The injured man was immediately transported to our hospital. The man was healthy without any medical diseases. On physical examination, the following parameters were recorded: temperature, 36.8°C; heart rate, 110/min; respiratory rate, 22/min; blood pressure, 115/75 mm Hg; and oxygen saturation, 97%. The rebar had pierced the perianal tissue on the right aspect of the anus towards the ramus ischiopubicusta (Figure 1). X-rays of the pelvis showed the depth of the rebar (Figure 2), and computed tomography



FIGURE 1 A rebar impaled the perianal tissue



FIGURE 2 X-rays of the pelvis demonstrating the rebar

indicated a normal peritoneal cavity. Based on the collective physical examination and imaging findings, emergency surgery was performed. The patient was carefully placed in the lithotomy position without moving the rebar (Figure 3). The severity of the rebar injury and exact position were unknown. The anal tissue was incised around the edge of the musculus sphincter ani externus, and the rebar was removed with extreme care (Figure 4). We then explored the depth of



FIGURE 3 The patient in the lithotomy position with a rebar in situ

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FIGURE 4 The length of the rebar

the injury along the path of the rebar. The ramus ischiopubicusta was fractured. The patient received a tetanus vaccine and antibodies and recovered shortly thereafter.

Impalement injuries are common in the emergency room; however, rebar impalement injuries, as in the current case, are rare. In the current case, it was a wise decision to cut the rebar at the base. Akhil et al¹ concluded that taking the patient directly to the operating room is better than first trimming the rebar. Other reports also suggest that minimal manipulation of the impaling object is crucial and recommend cutting the impaling object at the ends to facilitate transport of the patient.^{2,3}

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CONFLICT OF INTEREST

The authors declare that they have no competing interests.

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