Unusual Foreign Body in Rectum

S H Waqar¹, M Tariq Abdullah², Zafar Malik³

Abstract

Foreign bodies in rectum are well documented and are mostly related to homosexual practices. General surgeons during their clinical career may encounter such unusual cases. We present a case of an adult male who presented in emergency department with an unusual lodged metallic foreign body in his rectum that was retrieved successfully.

Keywords: Foreign body, Rectum, homosexual

Introduction

Anorectal foreign bodies are encountered more frequently in clinical practice nowadays.¹ Such practice is most often related to sexual behavior, however can also result from ingestion or sexual assault.² Foreign bodies inserted in the rectum and their management have been reported in the literature with dating back to 16th century.³,⁴ Various foreign bodies and their management have been reported, including bottles, spray cans, hosepipes, money, iron bars, and sex toys. Sex toys such as vibrators are used frequently, and their misuse poses the risk of serious injuries such as perforation.⁵ Presentation to the hospital is usually delayed and is always due to embarrassment. Patients present to the emergency department because of pain, discomfort, or rectal body sensation, often multiple attempts to remove the object.⁶ Foreign bodies lying above the sacral curve or rectosigmoid junction are difficult to visualize and remove; while low-lying rectal objects are normally palpable on per rectal examination and can be removed in the emergency department. We present a case of self-introduced foreign body of stainless steel in rectum that was removed successfully.

Case Report

A 25 years old male presented in the accident & emergency department with two days history of pain in rectum. He was not accompanied by anyone. On further questioning, he admitted to having a foreign body in the rectum. He was unmarried, non-addict and gave no previous history of any psychiatric illness. On examination he was vitally stable, his abdomen was soft, non-tender, non-distended and bowel sounds were audible. Inspection of the perianal area showed no apparent abnormality. On digital rectal examination, a firm, metallic foreign body was felt on the tip of index finger three to four centimeter from the anal verge. A plane abdominal radiograph was done that showed 4x6 cm cylindrical object in the rectal area. (Figure 1)

Figure 1. Radiograph Showing the Foreign Body
An effort was made in the emergency room to remove the foreign body but failed. The patient was shifted toward and consent was taken for removal under anaesthesia. In the operation theatre, under spinal anaesthesia in the lithotomy position with the patient sedated, a transanal attempt was made to retrieve the foreign body. A stainless steel foreign body was held firmly with the help of Kocher’s forceps and foreign body was removed successfully. (Figure 2)

The object seemed to the top of a water tap and the posterior rectal mucosa was firmly impacted in the edge of the object. After removal of foreign body, per rectal examination did not reveal any colorectal injury except some minor mucosal tears. Recovery was uneventful and the patient did not develop a perianal infection or anal incontinence. Postoperatively the patient was shifted to ward for observation. He was kept nil per oral on intravenous fluids under antibiotic cover; but on the third night he left the ward against medical advice.

**Discussion**

The majority of case series of a foreign body in rectum are reported from Eastern Europe, while such reports are uncommon in Asia. Males are commonly affected. Rectal foreign bodies present the modern surgeon with a difficult management dilemma, as the type of object, host anatomy, time from insertion, associated injuries and amount of local contamination may vary widely. Reluctance to seek medical help and to provide details about the incident often makes diagnosis difficult. Management of these patients may be challenging, as the presentation is usually delayed after multiple attempts at removal by the patients themselves have proven unsuccessful. Further attempts by the patient himself may cause ano-rectal mucosal tears, that lead to local oedema, inflammation, or muscle spasms. Our patient is male, who initially gave the only history of rectal pain and was reluctant to give true history. Later on further questioning, he admitted having a foreign body in his rectum.

The foreign body in the rectum can be diagnosed with history, physical examination (digital rectal examination) and can be confirmed by a plane radiograph. We diagnosed clinically this case by DRE and confirmed it by a plane x-ray abdomen.

Generally, foreign bodies in the rectum are classified into high and low depending on its relation to the rectosigmoid junction. Low lying are placed in the rectal ampulla whereas high are located above the recto sigmoid junction. This classification has been used as a general rule to retrieve foreign bodies. For uncomplicated low-lying foreign bodies, transanal extraction can be achieved by digital manipulation or using various grasping forceps through proctoscopy, anal retractor or rigid sigmoidoscopy. As anal spasm can hold the foreign body away from anus, adequate relaxation is often needed. In difficult cases, extraction may require complete relaxation of anal sphincters by local, regional or even general anaesthesia.

For high-lying foreign bodies, trans-anal extraction can still be successful, but they are more likely to require a general anaesthesia. For patients presenting with frank peritonitis, laparotomy is mandatory to remove the foreign body, repair the perforation and perform surgical lavage. A defunctioning stoma may sometimes be needed. In our case; we were able to retrieve successfully a metallic foreign body under spinal anaesthesia and sedation.

It is very important not to humiliate or degrade the patient about his condition and the approach should be as to any other surgical patient. Psychiatric consult should be sought while managing these patients.

**References**