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Rectal Foreign Body: A Case Report

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Abstract: ***Rectal foreign body are nowadays not a rare condition frequently has been described in the medical literature. Most cases can be managed by retrieval of foreign body per rectum under anaesthesia using some ingenuity. Some cases may require laparotomy. A 40 year old male patient admitted in general surgery department with chief complain of generalized abdominal pain with not passing stool and accidentally inserted foreign body in the rectum. Retrieval of foreign body trans anal under general anaesthesia was successful and post operative period was uneventful.***

Keywords: Rectal foreign body, laparotomy, sigmoidoscopy

1. Introduction

Rectal foreign body insertion intentional or unintentional nowadays are not a rare presentation [**1**]. Emergency Surgeon seldom encounter cases of foreign body ingestion/insertion [**2**]. Rectal foreign bodies often related to sexual gratification, sexual assault or result of ingestion and rarely accidental and with rising incidence [**3**]. Mostly seen in males of 3rd and 4th decades [**4**]. The vast majority objects are inserted by self-introduction in children and psychiatric patients [**5**]. Management of foreign body in rectum challenging for surgeon due to variation of time of insertion, associated injuries, and type and location of an object [**6**].

2. Case Report

A 30-year-old married male presented to surgery department with alleged history of accidental insertion of iron rod through anus 7 days prior. He denied purposeful insertion. He had complained of not passing stool and flatus since 7 days which is associated with generalised abdominal pain and rectal pain and multiple episode of vomiting and no any per rectal bleeding. He had tried to remove iron rod himself but had been unsuccessful. There was no any abdominal distention. There were no any comorbidities and no any history of psychiatric illness. The patient mood, behaviour pattern and insight were are normal at the time of examination.

On physical examination the abdomen is soft and nontender and foreign body palpated near the infraumbilical region and there were no any signs of peritonitis. On digital rectal examination the anal tone was intact and no any external injury was seen and lower margin of iron rod palpated at 3 cm proximal to anal verge which is solid in nature and approx. diameter of 3 cm.

Patient was admitted and investigated and all routine investigation were within normal limits. Plain x ray of his abdomen showed foreign body resembling solid rod like structure in rectum and up to sigmoid colon but no any evidence of pneumoperitoneum (figure 1 and 2).

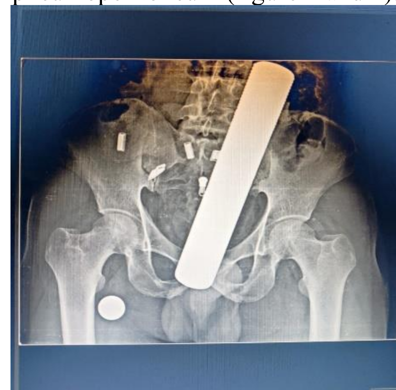

Figure 1: Showing foreign body

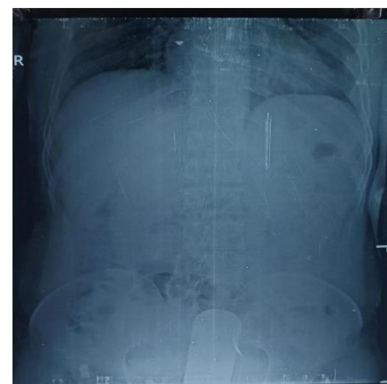

Figure 2: No any evidence of perforation

Abdominal xray was normal

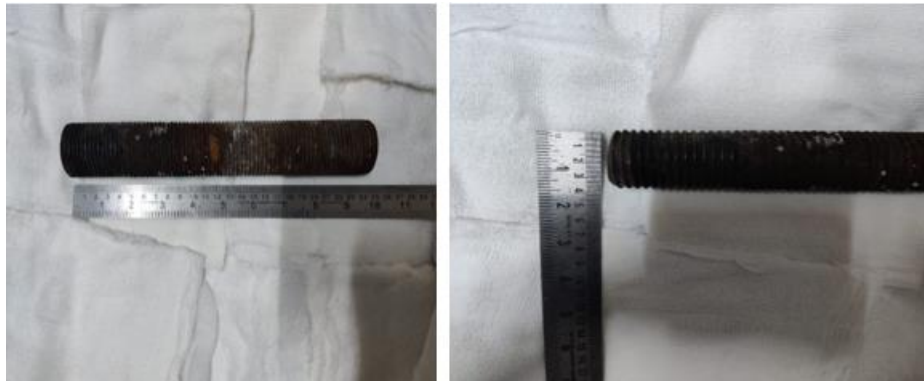

Figure 3: Retrieved iron rod which is 25 cm in length and 3.5 cm diameter

Patient and his relatives were explained about various modalities of surgeries and its complication. After taken all consent from patient and relatives' retrieval of foreign body under general anaesthesia by manually and it was successful. On proctoscopy examination after retrieval of iron rod which is wrapped in polythene bag there was only blanching of rectal mucosa found at 5 to 9 'o clock region which is extend up to 7 cm from anal verge. Patient was passing stool on post op day 1 and no any rectal bleeding associated with it. Patient was discharged on post op day 3.

3. Discussion

There are multiple case reports on rectal foreign bodies. Commonly reported objects are beetal nuts, batteries etc. in involuntary ingestion while beverage bottle and candles are more commonly associated with sexual gratification. Iron rods, wooden handles are common among victims of sexual assault [**4**]. Rectal foreign body are common among drug traffickers known as body packing [**7**]. Men have higher incidence compared to women and rectum and sigmoid colon are the commonest site for lower GI tract foreign body [**8**].

These patients typically present to emergency department in delayed fashion because of embracement and often multiple attempts of self-removal. Patient usually present varies from asymptomatic cases to florid peritonitis depending upon the type of rectal foreign bodies, time of insertion, way of insertion and absence of non-professional removal of foreign body [**9**].

Patients commonly presents with most commonly abdominal pain, rectal bleeding, constipation and often presents after multiple attempts of removal. In case of perforation patients presents with fever, vomiting and abdominal pain and sign of sepsis. In these complicated cases patient require resuscitation by parenteral hydration and broad-spectrum antibiotics with urgent exploratory laparotomy [**10**].

The presence of tarry mucoid rectal discharge with necrotic odour raises the suspicion of gangrenous rectum. Plain abdominal and pelvic x ray required to determine the presence, number, shape, size, location, and direction of foreign body which is important for planning of the extraction programme [**9**]. Due to delayed presentation wide variety of rectal foreign bodies causes severe injuries and damage rarely from mucosal injuries to free intestinal perforation which is difficult to diagnose and leads to sepsis and death [**11**].

Rectal foreign body classified as high lying or low lying depending on their location relative to rectosigmoid junction. Low lying rectal foreign body palpable by digital rectal examination and candidates for trans anal removal [**12**].

Extraction of foreign body has wide variety of techniques. About 67 - 75% of rectal foreign body removed via trans anal approach [**10**]. If a foreign body present within 10 cm of anal verge and no signs of peritonitis are present these approaches are helpful. Colonoscopy and sigmoidoscopy are also reported with good success to retrieve foreign body under direct vision to avoid iatrogenic injuries [**13**].

Laparotomy only indicated when trans anal or endoscopic removal fails or if complications like perforation, peritonitis. In laparotomy aim is trans anal removal and closure of the operation with diversion colostomy [**14**]. In our case, foreign body (iron rod) removal in general anaesthesia trans anally and post - op period was uneventful.

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