VOLUME-7, ISSUE-3, MARCH-2018 • PRINT ISSN No 2277 - 8160

Original Research Paper

General Surgery

POLYEMBOLOKOILAMANIA CAUSING RECTO-SIGMOID PERFORATION

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ABSTRACT Polyembolokoilamania is a disease entity in which one inserts foeeign objects inside the body orifice.Here we are reporting a case of recto sigmoid injury due to autoerotic activity with rectal foreign body was identified in a male patient. The object was a wooden rod. That was extracted by doing laprotomy & divertion loop sigmoid colostomy.

KEYWORDS :

Introduction

Rectal foreign bodies (RFBs) inserted in the rectum and their management have been reported in the literature with dating back to 16th century . RFBs are settled in the rectum via either of two ways: those inserted per annum and more rarely ingested by the mouth . The oral way is the case mostly encountered in those with poor intellect, mentally retarded, and senile or debilitated persons, also in drug trafficking. On the other hand, RFBs inserted in the rectum per anally are noted most commonly in middle-aged men in context of autoerotic instrumentation . In this article we described a patient admitted to the emergency department (ED) with RFB related autoerotic activity and reviewed management options in the literature

Case report

Mr A, a 51-year-old man, brought himself to the emergency department (ED) when he was unable to remove a wooden rod from his rectum. On several occasions he had inserted the same rod and had removed it without difficulty. Unfortunately, this time it had penetrated so far that he could not grip the edge and remove it. this led to recto sigmoid perforation that required an exploratory laparotomy and repair.

On examination,the patient was conscious &oriented,febrile, dehydrated. Pusle rate – 130/min BP -100/70 mmhg ,By examining the abdomen he was found to have severe diffuse tenderness guarding & rigidity .Per rectal examination – tip of the rod as felt in rectum approx. 4 cm from anal verge .Xay abdomen shows air under the diaphragm .laboratory values were notable only for a white blood cell count of 17000 cells/mm3.

The patient had been taken-up for emergency laparotomy . The recto-sigmoid junction was found to be perforated by the foreign body.the margins of the perforation was trimmed & the perforation was primarily closed.sigmoid loop colostomy (covering) was done. Post operative period was uneventful.post operatively psychiatric counselling was given & he was discharged on 10thpost operative day

6 weeks later he was admitted & colostomy take down was done.we are following up the patient.thereno behavioural recurrence now

Figure 1 : intraoperative picture of rectal foreign body

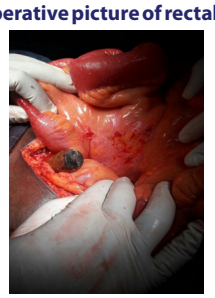

Figure 2 :intra operative picture of rectal foreign body

WHO INSERTS FOREIGN OBJECTS INTO BODILY ORIFICES?

Individuals who insert foreign objects into their own bodily orifices span disparate backgrounds, ages, and lifestyles. Children (under the age of 20 years) commonly swallow foreign bodies, accounting for approximately 80,000 cases each year; most of these are accidental ingestions in children between the age of 6 months and 4 years.1 Younger boys swallow foreign bodies more often than do younger girls. In adolescents, intentional foreign body insertion often reflects risk-taking, attention-seeking, or poor judgment while under the influence of drugs or alcohol or as a manifestation of psychological abnormalities.2 Adolescent girls with eating disorders (ie, bulimia or anorexia nervosa) exhibit a propensity for toothbrush swallowing.3 Adults who insert foreign objects often suffer from mental illness, harbor lingering curiosities that manifest as experimentation or as efforts to rekindle past experiences or relationships, or do so to enhance sexual stimulation

WHAT DO PEOPLE INSERT INTO ORIFICES?

While the list of objects that patients insert into their orifices is long and sundry, most are common household objects (eg, beans, dried peas, popcorn kernels, hearing-aid batteries, raisins, beads, coins, chicken bones, fish bones, pebbles, plastic toys, pins, keys, buckshot, round stones, marbles, nails, rings, batteries, ball bearings, screws, staples, washers, pendants, springs, crayons, toothbrushes, vases, razor blades, soda cans and bottles, silverware, hinges, telephone cable, and guitar picks).

Foreign bodies can enter the human body by swallowing (the mouth/upper gastrointestinal [GI] tract), insertion (eg, nose, ears, penis/urethra, vagina, rectum (lower GI tract), fistulas, ostomy sites), or traumatic force, either accidentally or on purpose.

insertion behavior can be identified and treated. Even in the absence of psychiatric illness, harm-reduction strategies may be taught to psychologically normal individuals who embrace the insertion behavior as a lifestyle preference.

Case discussion

Mr A's rectal foreign body insertion could well have been a

consequence of several conditions. Common potential etiologies include sexual gratification, self-injury (to inflict pain, embarrassment, punishment [possibly to alleviate mental anguish]), psychosis (eg, to obey command hallucinations or to diminish some perceived bizarre threat through that bodily territory), reexperience of nostalgic memories with high affective valence, compulsivity (eg, to relieve anxiety associated with not performing this activity), and factitious illness[1].

The psychiatry consultant identified 2 potentially useful interventions: (1) to reduce the harm of future foreign object insertion, given the likelihood that the behavior would recur, and (2) to mitigate the shaming effect of the hospital experience, so that it might begin a working through of his complex emotional experience around the insertion behavior rather than a mere repetition of prior shame-inducing exposures earlier in life. The 2 aims were related insofar as Mr A needed to tolerate thinking and talking about the insertions in order to become receptive to harm-reduction interventions and any indicated treatment recommendations[2,3].

Foreign bodies in the rectum are known for potential complications and present as a challenge to clinical management. The variety of objects removed from therectum almost defies imagination

The incidence varies according to region, said to be uncommon in Asia and most common in Eastern Europe . Although retained rectal foreign bodies have been reported in patients of all ages, genders, and ethnicities, more than two-thirds of patients with rectal foreign bodies are men in their 30s and 40s, and patients as old as 90 years were also reported .Rectal foreign bodies usually are inserted, with the vast majority of cases, as a result of erotic activity. In these cases,the objects are typically dildoes or vibrators, although almost any object can be seen, including light bulbs, candles, shot glasses, and odd or unusually large objects such as soda bottles, beer bottles, or others. Other causes for insertion include diagnostic or therapeutic purposes, self-treatment of anorectal disease, criminal assault and accident[5-7] . Few cases in the literature described foreign bodies in the rectum in association with Munchausen's syndrome .Munchausen's syndrome is a term for psychiatric disorders known as factitious disorders wherein those affected feign disease, illness, or psychological trauma in order to draw attention or sympathy to themselves. It is also sometimes known as hospital addiction syndrome or hospital hopper syndrome

Assumptions of erotic activity as the cause forinsertion of foreign bodies into the rectum may lead to the diagnosis of Munchausen's syndrome being missed.

Some rectal foreign bodies are initially swallowed and then transit through the GI tract. Examples of the latter include toothpicks, popcorn, bones, and sunflower seeds . In older men, the objects may be introduced to aid in manual disimpactionfor constipation or to massage the prostate. Rectal foreign bodies present a difficult diagnostic and management dilemma because of delayed presentation, a variety of objects, and a wide spectrum of injuries so that nosingle procedure for their removal can be recommended[8]. An orderly approach to the diagnosis, management, and postextractionevaluation of the patient with a rectal foreign body is essential .Most patients with rectal foreign bodies present to the emergency room usually after efforts to remove the object athome. A detailed clinical history and physical examination are essential for the diagnosis and management of these lesions, in addition to any other diagnostic techniques that might be necessary. The first step in the evaluation is that one should always be aware of the possibility of a large bowel perforation and perform radiological investigations[9]. Plain abdominal radiography or

soluble contrast enemas may be helpful. An abdominal X-ray will also provide information on the localization of the foreign body, whether it is below or above the rectosigmoidjunction. If perforation of the bowel has occurred, immediate laparotomy is warranted. If there are no signs of perforation, several management approaches can be tried .

Rectal foreign bodies can be classified as high-lying or lowlyingdepending on their location relative to the rectosigmoid junction. This distinction is important. Objects that are above the sacral curve and rectosigmoid junction are difficult to visualize and remove, and they are often unreachable by rigid sigmoidoscope. Soft or low-lying objects having an edge could be grasped and removed safelyin the emergency department, but grasping hard objects was potentially traumatic and occasionally resulted in upward migration toward the sigmoid .Frequently, delay in presentation as many patients may be embarrassed and reluctant to seek medical care together with multiple attempts at self-removal lead to mucosal edemaandmuscular spasms, further hindering removal. Rectal lacerations and perforations may occur but are less common than other complications[5].

A large number of surgical and non-surgical techniques have been described to remove rectal foreign bodies .The approach to remove a foreign object in the rectumdepends on the type of object as well as the location withinthe rectum.

The majority of retained foreign bodies can be removed on an outpatient basis. If removal is not immediately possible, the patient should be admitted for observation and removal of the foreign body transanally under anesthesia .Most objects can be removed either manually or by using different instruments. Historically, various instrument were used to assist transanal removal including use of flexible and rigid sigmoidoscopy , colonoscopy , obstetric forceps and obstetric vacuum. Laparoscopic-assisted removal is also described by someauthors[10].

Laparotomy is only required in impacted foreign bodies and or with perforation peritonitis. Even with laparotomy, the aim is transanal removal and closure of perforation with diversion colostomy. Postretrieval colonoscopy is mandatoryto rule out colorectal injury . The complications of insertion of these materials include rectal bleeding, mucosal lacerations, anorectal pain, bowel perforations, abscesses and rarely death .

Conclusion

Rectal foreign bodies present a difficult diagnostic and management dilemma because of delayed presentation, a variety of objects, and a wide spectrum of injuries so that no single procedure for their removal can be done.Frequently, delay in presentation together with multiple attempts at self-removal lead to mucosal edemaandmuscular spasms, further hindering removal. Most objects can be removed either manually or by using differentinstruments. Laparotomy is only required when there is failure of transanal removal as in high or impacted foreign bodies and in presence of evidence of perforation peritonitis

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