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Original Research Paper

Surgery

A CASE REPORT OF RECTAL FOREIGN BODY

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ABSTRACT

Rectal foreign bodies (RFB) pose a challenging management for today's surgeons since the type of object, host anatomy, time since insertion, concomitant traumas, and level of local contamination can all be very different. Diagnosis is frequently complicated by reluctance to seek medical attention and to provide information about the incident. The management of these patients might be difficult because they typically present after numerous unsuccessful attempts to be removed by the patients themselves. In this article we report the case of a male who presented with a large glass bottle wedged into his pelvis. As we were unable to extract the object with routine transanal and it was extracted by laparotomy approach.

KEYWORDS :

INTRODUCTION

Rectal foreign bodies (RFB) have been documented since the sixteenth century.[1] Their prevalence is increasing, particularly in urban areas.[2] Men are more frequently encountered, and the typical age of presentation is 44 years.[2] Although there are many objects put in the rectum, glass bottles are by far the most prevalent (42.2%).[3] Rectal foreign body insertion has a variety of purposes, including sexual enjoyment, concealment—as in the case of body packers—sexual assault, and, very rarely, unintentional causes. However, the most prevalent reason is autoeroticism because more people are using other objects for anal intercourse.[4][5] The presentation might happen at any time; some people contact emergency services right away due to their incapacity to get the object out. Additionally,The timing of presentation varies; some people contact emergency services right away because they can't get the object out of their way. Other patients, who may be embarrassed, may delay their presentations for up to two weeks. Such patients frequently try to hide the truth about how they presented to the emergency room, even after they arrive.[6] The removal of a foreign body from the rectum can be accomplished via a variety of methods. With the development of technology came new removal techniques like laparoscopy, endoscopy, and minimally invasive surgical options. In this paper, a review of these operations, their indications, complications, and clinical relevance will be covered.

Case Report:

36 years old Male with history of self insertion of brandy bottle into the anus, history of alcohol intoxication. On examination, Patient Vitals were stable. On Per abdomen –soft, not tender. Digital rectal examination- mouth of bottle seen. Routine blood investigations- within normal limits

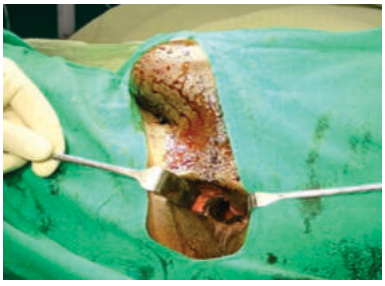


Fig 1: Foreign Body In Rectum (bottle Mouth In The Anal Canal)

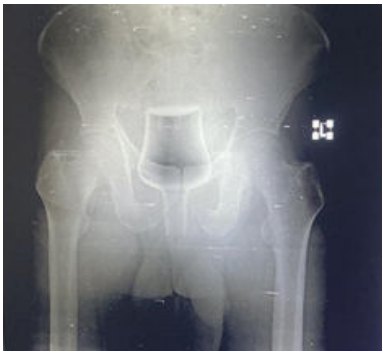
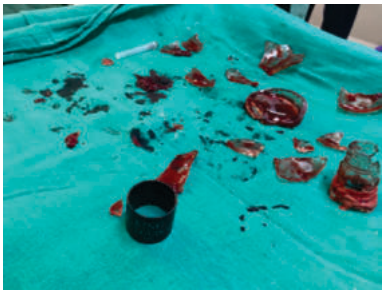


Figure 2: Xray Of Pelvis- Foreign Body Rectum – (alcohol Bottle).

Under spinal anaesthesia, in lithotomy position manual removal of foreign body was attempted- failed multiple times and hence Proceeded with lower midline laparotomy. Bottom of the bottle struck at the level of pelvis, one person through the laparotomy incision reached the rectum and base of bottle is pushed and another person through the anal canal pulled the bottle mouth. Accidentally Bottle got broken in the rectum , broken pieces were delivered out of rectum and Hartmann's procedure was done. Postoperatively after 6 weeks sigmoidoscopy was done, rectum were found to be normal and planned for ostomy reversal.



CASE DISCUSSION:

Rectal foreign bodies constitute a proctological emergency. Numerous approaches have been described in the literature that can be used to extract RFBs with their number as large as the variety of foreign bodies reported. One should move from the least invasive to complex, more invasive approaches. The majority of foreign bodies can be removed by the transanal

approach. The standard technique for the transanal approach involves the combined use of analgesia, sedation, anesthesia, and an attempt at manual removal of the foreign body[2]. Manual extraction should be attempted first, and if unsuccessful, may be removed in the operating room. Manual removal success depends on the size of the clinician's hand and the adequacy of anal sphincter relaxation.

The use of atraumatic surgical instruments such as uterine clamps or suction devices used in obstetrics has also been reported, though it may be difficult when the RFB is smooth.

Other techniques:

- Magnets to removal metal objects.
- Using clamps to break up organic material, such as fruit or vegetables, into smaller, easier to removal pieces.
- Inflating a Sengstaken-Blakemore tube inside objects, like a bottle or a jar, to provide traction.
- Obstetrical vacuum device.

Some patients may need more advanced approaches if bedside manual removal is unsuccessful. At times manual extraction may be successful in the operation suite due to deeper sedation levels and relaxation of the sphincter. 55% of patients that have RFB proximal to sigmoid required operational intervention[6]. Objects in the distal sigmoid colon may be removed with a flexible sigmoidoscope where the polypectomy snares can be wrapped around the object and air can be insufflated to break the seal[2]. Another advantage of sigmoidoscopy is that the mucosa can be easily evaluated for injury after removal. Another approach for RFB removal is a transanal minimally invasive surgical technique (TAMIS). A laparoscopic trocar is placed through the anus and hubbed to create a seal. The rectum can then by insufflated and laparoscopic graspers are used to grab the object[15]. A more invasive approach includes laparoscopy and laparotomy, where the object is milked towards the rectum for manual removal. If there is suspected perforation, a colostomy may be performed for transabdominal removal, and a Hartmann procedure with colostomy may be done based on the severity of patient condition.

CONCLUSIONS

The rectum is susceptible to perforation by foreign bodies because of its curvature and location close to several tissues. The most terrible outcome from a foreign body in the rectum is perforation, which, if it is not confined, can result in peritonitis. Local abscess formation may occur if the perforation is confined. Injuries from a sharp item may also affect neighbouring organs, such as the bladder or vagina, and cause vesicorectal and rectovaginal fistulas. A foreign body should be removed as soon as possible. Delays in foreign body removal might cause edoema and colon perforation, necessitating a challenging intraabdominal operation to remove the foreign body.

REFERENCES:

1. Kurer MA, Davey C, Khan S, Chintapatla S. Colorectal foreign bodies: a systematic review. Colorectal Dis. 2010 Sep;12(9):851-61. [PubMed]
2. Goldberg JE, Steele SR. Rectal foreign bodies. Surg Clin North Am. 2010 Feb;90(1):173-84, Table of Contents. [PubMed]
3. Cologne KG, Ault GT. Rectal foreign bodies: what is the current standard? Clin Colon Rectal Surg. 2012 Dec;25(4):214-8. [PMC free article] [PubMed]
4. Clarke DL, Buccimazza I, Anderson FA, Thomson SR. Colorectal foreign bodies. Colorectal Dis. 2005 Jan;7(1):98-103. [PubMed]
5. Caliskan C, Makay O, Firat O, Can Karaca A, Akgun E, Korkut MA. Foreign bodies in the rectum: an analysis of 30 patients. Surg Today. 2011 Jun;41(6):795-800. [PubMed]
6. Lake JP, Essani R, Petrone P, Kaiser AM, Asensio J, Beart RW. Management of retained colorectal foreign bodies: predictors of operative intervention. Dis Colon Rectum. 2004 Oct;47(10):1694-8. [PubMed]
7. Barone JE, Yee J, Nealon TF. Management of foreign bodies and trauma of the rectum. Surg Gynecol Obstet. 1983 Apr;156(4):453-7. [PubMed]