



Unusual Multiple Foreign Bodies in Rectum-A Case Report

KEYWORDS

Foreign bodies; Rectum; Complication

Dr. Chandra Mauli Upadhyay

Assistant Professor, Department of Surgery
Jawaharlal Nehru Medical College, Aryabhata
Knowledge University, Bhagalpur, Bihar

Dr. Prof. Upendra Nath

Professor and Head, Department of Surgery
Jawaharlal Nehru Medical College, Aryabhata
Knowledge University, Bhagalpur, Bihar

Dr. Sunita

Final year Postgraduate, Department of Surgery, Jawaharlal Nehru Medical College, Bhagalpur, Bihar

ABSTRACT

Now a days the incidence of foreign bodies in rectum along with its complications are increasing in emergency surgery. It is due to either from an orally ingested object that becomes impacted or more commonly due to insertion of objects through the anal canal. Unless there is a sign of peritonitis, the use of less invasive techniques is preferred for FB retrieval. Here, we present a case of a 18 year old male patient with 7FBs (bottles of different sizes) along with multiple seeds of wild fruit in rectum introduced as sexual perversion.

Introduction

In recent years, the incidence of patients presenting with rectal foreign bodies (FBs) has been increasing. While mouth reception types are mostly encountered in children with mental disabilities, rectal insertive types are mostly used in teenagers & middle-aged men for sexual stimulation [1, 2]. It may cause serious surgical complications.

Background

Rectal foreign body insertion has been sporadically described in published reports. One of the earliest case reports was published in 1919, although Haft and Benjamin referred to a case as long ago as the sixteenth century. Objects can be inserted in to the rectum for diagnostic or therapeutic purposes, self-treatment of anorectal disease, during criminal assault or accidents, or (most commonly) for sexual purposes. Most objects are introduced through anus; however, sometimes, a foreign body is swallowed, passes through the gastrointestinal tract, and is held up in the rectum. Numerous objects, including billy clubs, various fruits and vegetables, nails, light bulbs, bottle, Impulse body spray cans, turkey basters have been described as retained rectal foreign bodies. In short practice of surgery (Bailey & Love) a picture of bell in the rectum is well depicted. One of the most common problems encountered in the management of rectal foreign bodies is the delay in presentation, as many patients are embarrassed and reluctant to seek medical care.

Because of the wide variety of objects and the variation in trauma caused to local tissues of the rectum and distal colon, a systematic approach to the diagnosis and management of rectal foreign bodies is essential. Even after extraction, delayed perforation or or significant bleeding from the rectum may occur. Hence, a stepwise approach that includes diagnosis, removal and post extraction evaluation is essential.

Case Report

We present here the case of a 18-year-old boy admitted to the emergency department with rectal pain and constipation. The boy was ambulatory. Pulse 78 /min, BP 120/82mm

Hg. On palpation abdomen soft, bowel sound present. Slight tenderness in the left iliac fossa. On examination there was no discharge or blood in anal region but anus was patulous. On DRE something foreign body was palpated in the rectum. Proctoscopy revealed multiple FBs of different size & color.

Emergency plain X-ray of abdomen showed multiple FB shadows in pelvis. Under general anaesthesia in lithotomy position, 7 plastic bottles of different sizes of perfume along with hundreds of seeds of fruits of a plant which was under premises of his house were removed one by one. Patient was advised to take nothing orally & kept on IV fluids, analgesics & a prophylactic antibiotics & was kept under supervision for 24 hours. His recovery was uneventful. He was discharged after 24 hours.



Discussion

Recently cases of rectal FBs have been encountered more frequently in clinical practice. Various objects have been described as retained rectal FBs, such as bottle, eggplant, vibrator used for sexual or erotic purposes, thermometer while applying medical treatment (as accident), irrigation catheter and enema container. Mouth reception types include dental prosthesis, needle and wood stick. Rectal pain and bleeding are the two main symptoms associated with rectal FB. It may cause perforation and acute abdominal pain. Sometimes, it can also be related with rectal and

vulvar abscess. Migration of FB to urinary and genital tract has been reported. Ooi et al reported that atypical gender behavior, lax anal sphincters and bloody or mucoid rectal discharge are the factors which raise the suspicion for FB.

The majority of FBs can be palpated at the middle rectum. If it is not possible to palpate, endoscopic and radiologic investigation should be performed. Plain abdominal X-rays are indicated in almost all cases; CT scans should be reserved for those with potential sepsis or equivocal peritoneal signs. Unless there is a sign of peritonitis, it may be appropriate to wait several hours for spontaneous removal. In all cases, an appropriate tetanus prophylaxis and a prophylactic antibiotic are indicated. The genitourinary tract should also be examined for trauma and, if indicated, treatment. If possible, retrieval of FBs below the rectosigmoid region should be conducted transanally under sedation in the lithotomy position, using forceps and anal extractors if necessary. If the patient cannot tolerate the pain, spinal or general anesthesia may be administered.

Often, use of the fingers is the most convenient and easiest means of retrieving FBs from the rectum. In some cases, use of a Foley catheter, colonoscope, or Sengstaken-Blakemore tube may be necessary for retrieval. The main principle is to retrieve the FB transanally; if fails, it is better to retrieve it transanally after laparotomy with the assistance of the milking maneuver. Bak et al described a novel approach to retrieval and removal of a rectal FB utilizing a single-incision laparoscopic surgery port. Colotomy is the last option in the retrieval of FBs. If blood is detected during rectal examination, a sign of mucosal injury, the grade of injury must be evaluated after retrieval by performance of rectosigmoidoscopy or contrast studies.

It has been reported that primary repair, proximal loop colostomy, sigmoid end-colostomy sigmoid end-colostomy and the Hartmann procedure, in combination with administration of wide-spectrum antibiotics according to the severity of peritoneal contamination, can be performed for the treatment of perforation. The mortality and morbidity rates of patients presenting with perforation above the peritoneal reflection have been reported to range from 2.5 to 20.0% and 20.0 to 40.0%, respectively.

Conclusion

It is important to consider that FBs in the rectosigmoid region may cause perforation, peritonitis, pararectal abscess, fistulisation and genitourinary system injuries. It is also important to remember that complications may occur during FB retrieval. Thus, unless there is a sign of peritonitis, the use of less invasive techniques is preferred for FB retrieval.

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