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An Unusual Case of Rectal Foreign Body With Rectal Injury

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ABSTRACT

Patients suffering from rectal foreign body injuries, entrapments or impactions can be divided in a few broad categories-voluntary versus nonvoluntary and sexual versus nonsexual. By far, the biggest category with retained foreign bodies is voluntary insertion for sexual stimulation. Here, we present a case report of 45 years old male who presented with foreign body rectum involving torture or sexual assault, which was retrieved after laparotomy and needed proximal loop diversion colostomy for associated rectal injury.

KEYWORDS Rectal injury, laparotomy, colostomy, foreign body

SUMMARY

A 45 years old adult presented to emergency department, S.N. Medical College with a foreign body in rectum after physical assault

since 48 hours which failed to pass spontaneously. Under anesthesia foreign body failed to be retrieved anally and lower midline laparotomy was performed. Foreign body(glass bottle with broken neck) was extracted from recto-sigmoid junction and a proximal loop diversion colostomy was done for associated second degree rectal tear.

CASE REPORT

A 45 years old male presented to emergency department with history of alleged foreign body impaction into anus for last 48 hours after intoxication and physical torture by some unknown persons. He complained of slight bloody rectal discharge and had not passed feces for same duration. On examination patient was moderately built and nourished with stable vitals. Per abdomen examination was within normal limits with bowel sound present. Digital rectal examination revealed normal anal tone with bloody soiling of finger. On further extension of finger into rectum, a broken bottle neck was palpated. X-Ray abdomen was normal study. Gentle attempts to remove bottle anally failed and patient was shifted to OT and under combined spinal and epidural anesthesia, foreign body failed to extract per anally and infraumbilical midline laparotomy was done. Large bowel was palpated along whole length and a foreign body was palpable at recto-sigmoid junction. Enterotomy was done and a glass bottle with broken neck was extracted. Again PR examination was done and revealed a second degree rectal tear on right lateral wall. A proximal loop diversion colostomy was done to allow primary healing of enterotomy site and rectal tear. Patient had an uneventful recovery and after four months patient had an colostomy closure.



Fig.1. Retreival of Foreign body from recto- sigmoid junction.



Fig.2. Retrieved glass bottle(Foreign body)

DISCUSSION

Colorectal foreign bodies are infrequent problems with diagnostic and management dilemma and are mostly associated with increased incidence of homosexuality and anal auto-erotism. Although retained rectal foreign bodies have been reported in patients of all ages and ethnicities, more than

two-thirds of patients with rectal bodies are men in their 30 s and 40 s[1].

Patients with retained foreign body commonly have a delayed clinical presentation. Social embarrassment and stigmas hinder patients from immediate medical care. A hope that antegrade peristalsis may lead to prompt resolution without medical intervention, may result in hours to days of delay. The angulations of the pelvis often will not cooperate with large objects that have traversed the levator ani plane. Common presenting symptoms include pain abdomen, constipation, rectal bleeding and mucous leakage. Acute peritonitis has to be ruled out. A gentle digital rectal examination is performed to access the location of foreign body as well as sphincter tone, bleeding and any associated injuries. In general foreign bodies in lower and mid rectum can be successfully removed transanally but once the object is slipped above the anorectal angle into the upper rectum and recto sigmoid junction, a laparotomy may be needed[3]. Our patient presented with glass foreign body slipped above levator ani with broken edge causing associated rectal tear which comes under category II as per Barone et al assigned prognostic categories based on levels of injury[2].

Category I: Retained foreign body without injury.

Category II: Retained foreign body with mucosal laceration.

Category III: Retained foreign body with sphincter injury.

Category IV: Retained foreign body with rectal perforation.

Regardless of their size, sharp objects, jagged edges and glass objects should be removed in the operation theatre under controlled conditions. The goal of a laparotomy is to assess rectal and sigmoid integrity and retrieval of foreign body. Our patient needed laparotomy with proximal diversion loop colostomy for associated rectal injury.

CONCLUSION:

The treatment of patients with retained rectal foreign bodies can be challenging for both the patient and surgeon. Respect for the patients situation in combination with surgeon ingenuity, is required to safely navigate through this event. The diagnosis is confirmed by plain abdominal radiographs and rectal examination. Laparotomy is reserved for patients with perforation or reserved for patients with perforation or impaction of the foreign body.

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