ORIGINAL RESEARCH PAPER

General Surgery

# RECTAL FOREIGN BODY – A DIAGNOSTIC SURPRISE FOR THE SURGEON : A CASE REPORT

**KEY WORDS:** Rectal foreign body (RFB), Digital Rectal Examination(DRE),transanally.

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**ABSTRACT**

Cases of Rectal foreign body (RFB) may be challenging in day to day surgical practice both in terms of diagnosis and management. RFB can be classified based on the mode of insertion- voluntary/involuntary or sexual/asexual. The clinical presentation may vary from vague symptoms like constipation to complications like perforation, peritonitis, etc. Many present with storied history and thus a detailed clinical examination especially a Digital rectal examination(DRE) and abdominal radiograph help in diagnosis. Management is crucial and retrieval of RFB may be done transanally,endoscopically or through laparotomy depending upon size, nature or location of RFB or associated injuries. This is a case of a gentleman with a large self inserted RFB which was retrieved transanally.

## INTRODUCTION

Cases of rectal foreign bodies (RFB} can be intriguing problems for the surgeon both in terms of diagnosis and management(1). The earliest case report was published in 1919 .RFB can be classified on basis of insertion i.e voluntary/involuntary or sexual/nonsexual. Most are inserted through anus and are more frequently encountered in males(2).Diagnosis of RFB is often difficult due to factors such as storied history, complaint other than that of RFB insertion , delay in seeking medical help, presence of psychiatric disorder etc(2). Hence a stepwise systematic approach including clinical evaluation, relevant investigations and removal along with post-extraction follow up is necessary.

## THE CASE :

A 50 years old gentleman presented himself unaccompanied at the general surgery OPD (SOPD) of Howrah District Hospital complaining of inability to pass stool for 3 days. There was no other gastrointestinal symptoms . There was no previous history of altered bowel habit including constipation .There was no history of any coexisting medical or surgical disease.

Patient was oriented,hemodynamically stable. Abdomen was soft, nontender,nondistended. Bowel sounds were reduced. No signs of perforation or peritonitis were present. DRE(digital rectal examination) revealed : hard hollow circumferential object with regular margin palpable just above the pectinate line - ? Rectal foreign body. No active bleeding per rectum was noted and anal tone was normal .

He underwent a straight X-ray whole abdomen and pelvis which revealed a long conical shaped foreign body located against the sacrum. ( **Figure A)**

The plan of management was examination under anaesthesia ( EUA) followed by transanal removal to be attempted first . If it failed then laparotomy was to be considered as endoscopy is not available at our hospital.

Patient was put under general anesthesia and in lithotomy position. Proctoscopy was done- RFB visualised as a circumferential black hollow object, upper extent of which was not palpable. Anal dilatation done. Lower circumferential end of RFB was grasped with Allis tissue forceps and RFB was delivered intact transanally by gradual controlled twisting movements.(**Figure B**). The RFB was 10 cm long conical, made of plastic with approx. 2.5 cm diameter at it's base as shown. ( **Figure C**)

Post operative period was eventful. Xray abdomen, abdominal examination and DRE were within normal limits.

Patient later revealed that he was on psychiatric medication and inserted the foreign body himself.Patient was discharged after 2 days as he was symtompless and passed normal stool . Patient was advised psychiatric consultation and regular follow up.

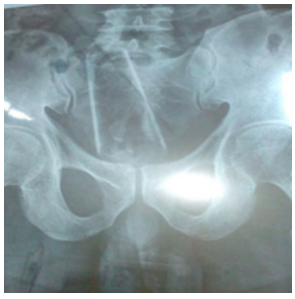

**Figure A. Xray showing large RFB**

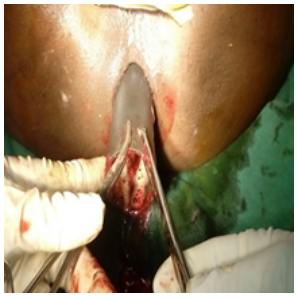

**Figure B. RFB removal being done transanally**

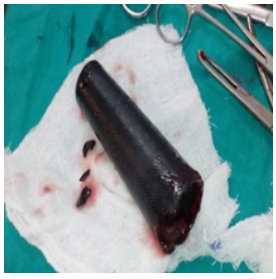

**Figure C. The RFB- plastic covering over handle of motorbike.**

## DISCUSSION

RFB should be managed in a well organised manner without much delay as fatal complications like perforation, peritonitis etc. can arise(3). As most cases can mislead us with storied presentations meticulous history taking, general, abdominal and rectal examination can help reach the diagnosis .Abdominal radiograph is confirmatory ,excludes bowel perforation. Manual removal through trans anal route with adequate anal sphincteric relaxation should be attempted first in stable patients. Laparotomy is reserved only for perforation, peritonitis, impacted /friable/sharp RFB or failed transanal approach as suggested by previous case studies(1). Endoscopic removal is practiced in some centres for more

proximal RFB. Newer techniques include TAMIS(transanal minimally invasive surgery) , minilaparotomy etc.

Proctosigmoidscopy should be done ideally in all patients after RFB removal to detect mucosal injury, lacerations, delayed perforations. Alternatively abdominal radiographs and DRE can be combined after RFB removal to asses delayed perforation if RFB has been removed transanally and if endoscopy is unavailable and patient may be discharged in 2-3 days if they are unremarkable .Regular follow-up and psychiatric evaluation in cases of voluntary insertion of RFB are mandatory to prevent recurrence of insertions.

## CONCLUSION

The diagnosis of rectal foreign body requires a high index of suspicion as often the patient presents with concealed history or vague abdominal symptoms like constipation without any complications. So a detailed evaluation especially DRE is necessary in all patients presenting with alteration of bowel habit and RFB can be an incidental finding which is confirmed by abdominal radiograph. Management of RFB should be done in a stepwise manner , transanal ( manual/ endoscopic) removal being attempted first which is often challenging and laparotomy to be reserved only for selected cases. Additionally, psychiatry consultation is warranted in cases of voluntary insertion of RFB. Thus we can see that ***despite all best practices, diagnosis and management of RFB still remains a challenge to the surgeon .***

Acknowledgements, conflicts of interest not declared.

## REFERENCES

1. Goldberg J.E., Steele S.R. Rectal foreign bodies. Surg Clin North Am. 2010;90:173–184.[tableofcontents][PubMed
2. Agarwal P: Long-standing retained foreign body in the rectum. The Internet JournalofSurgery;2009Volume18Number2
3. Ruiz del Castillo J, Sellés Dechent R, Millán Scheiding M, Zumárraga Navas P, AsencioAranaF:Colorectaltraumacausedbyforeignbodiesintroducedduring sexual activity: diagnosis and management. Rev Esp Enferm Dig; 2001; 93(10): 631-4.