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*RESEARCH ARTICLE*

# STUCK UP!!!- CASE REPORT OF A RECTAL FOREIGN BODY

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## *Abstract*

Rectal foreign bodies have a been a part of history for causing anorectal trauma. The first described report on the management of retained rectal foreign bodies dates back to the 16th century,and the first case reports of the modern era were published in 1919. The mean age at presentation is 44 years with a decidedly higher proportion of male patients.Mostly the foreign body found in rectum are inserted with an attempt to hide illegal objects or for sexual activities, and patients do not share complete and proper history with the treating doctor because of Embarrassment which complicates the management. We present a case of 30-year-old /M, who works in a plastic factory presented to casualty with c/o Constipation and Abdominal pain. On Detailed History the Patient explained the incident of inserting a self-made plastic tube in the Rectum which failed to come out on trying. On Xray Abdomen Erect s/o dilated bowel loops, with no gas under diaphragm. CECT showed large oblong foreign body in Rectum. Patient was taken to operating room and Manual removal of Foreign Body done under Spinal Anaesthesia. Foreign body was found to be a tubular, blunt, atraumatic plastic tube. Thus, we present a case of Rectal Foreign body which could be removed without operative intervention as the object was blunt and patient presented early to casualty.



## Introduction:-

Rectal foreign bodies have a been a part of history for causing anorectal trauma. The first described report on the management of retained rectal foreign bodies dates back to the 16th century,and the first case reports of the modern era were published in 1919. The mean age at presentation is 44 years, but ranges from 20 to over 90 with a decidedly higher proportion of male patients.

The most common reason, by far, for anal FB insertion is sexual pleasure, however other documented explanations include drug concealment, assault, “accidental”, psychiatric reasons, and to alleviate diarrhea or constipation [1–3]. Careful investigation and a high index of suspicion is required as patients are often reluctant to share the etiology of their presentations.

Abdominal radiography is necessary to ascertain the diagnosis. Treatment includes attempt at manual/endoscopic removal of foreign body under anaesthesia, proximally migrated Foreign bodies that cannot be retrieved by above

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method or if there is physical evidence of peritonitis warrants an urgent laparotomy. Early diagnosis of retained rectal Foreign bodies is likely to result in less invasive or non-operative management.

This type of injuryhappens too infrequently for any single institution to accumulate enough cases for meaningful statistical analysis. Most of the data published are case reports, surgeon experience, and retrospective analysisof hospital specific outcomes.Thus, we present a case of 30 year Male who inserted a self madePlastic tube in Rectum.

**Case Report**

A 30 year old unmarried male, working in a plastic factory presented to casualty with complaints of obstipation and abdominal pain since 1 day which was insidious in onset, gradually progressive associated with nausea and constipation. Patient appeared very hesitant at first but later on counselling and taking detailed history, patient revealed the incident of inserting a self-made plastic tube in the rectum. He had history of similar episodes of foreign body insertion in the past. However on this particular incident he was unable to withdraw the plastic tube manually.

On general examination patient was vitally stable. On Per Abdominal examination- Abdomen appeared distended, with no tenderness, guarding or rigidity. A smooth swelling was palpable above the umbilicus approximately 5x4cm with no visible pulsations or peristalsis, bowel sounds were sluggishly present. Per rectal examination was done which showed - Anal tone was normal with no ballooning and a foreign body felt at the tip of finger which was smooth and there was no active bleeding.

Radiological investigations were done. X-Ray Abdomen erect was done after pushing approx 100ml air through RT which was suggestive of dilated bowel loop with no free gas under diaphragm. As patient was vitally stable, CT Abdomen and Pelvis was done to further evaluate the nature of Foreign body inserted and its distance from Anal verge. CT Abdomen and Pelvis showed Large Foreign Body about 18 cm in Rectum, 6cm away from anal verge.

Patient was taken for emergency procedure, under spinal anaesthesia manual removal of foreign body attempted which was successful.

Thorough examination was done with proctoscope after foreign body removal which showed no Internal injuries nor any external injuries noted. Foreign body extracted was found to be a blunt, tubular,atraumatic Smooth Plastic tube which was 22cm in length.

Post operatively X-ray abdomen was done which showed no free gas under diaphragm. Rest Post Operative period was uneventful.

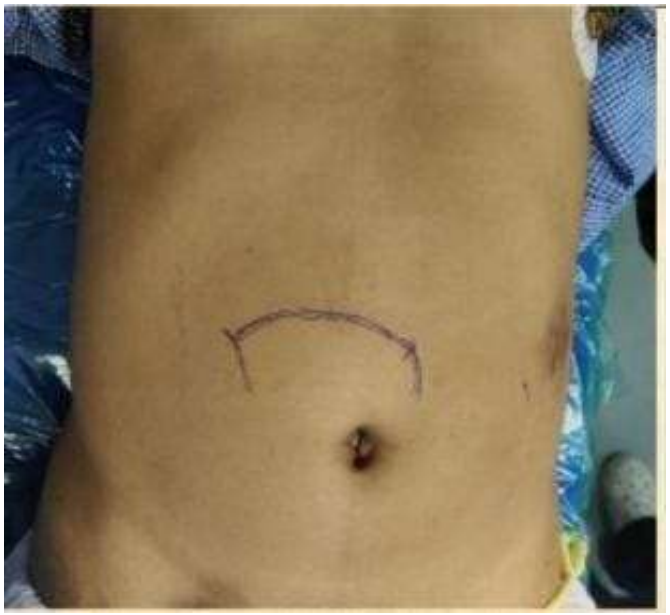

**Fig 1:-** Preoperative marking of Smooth swelling Palpable above Umbilicus.

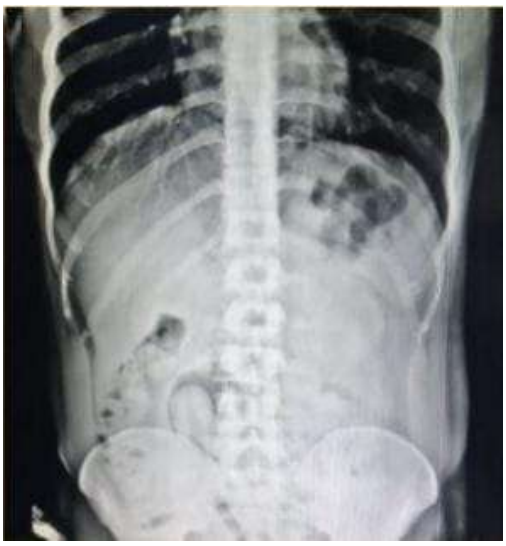

**Fig 2:-** X-ray Abdomen showing dilated Bowel loops.

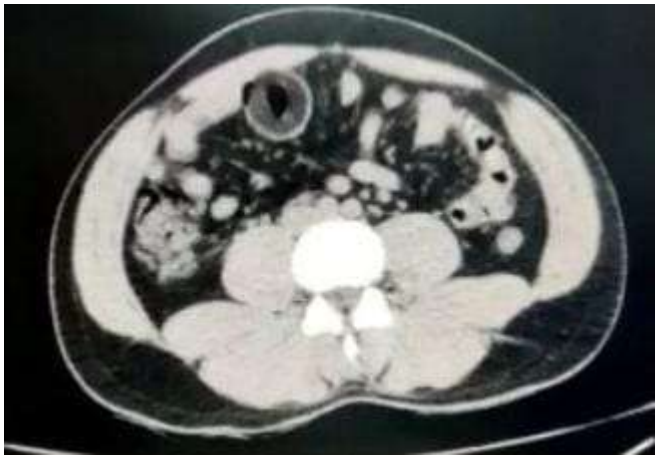

**Fig 3:-** CT showing- Large oblong Foreign Body in Rectum.

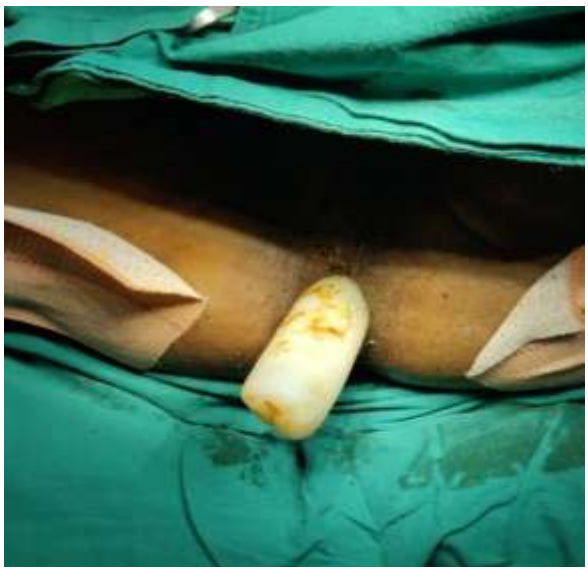

**Fig 4:-** Intraoperative picture showing manual Rectal Foreign Body extraction under Spinal Anaesthesia.

**Fig 4:-** Extracted Rectal Foreign Body 22cm Smooth Plastic Tube.

## Discussion:-

Insertion of foreign body in the rectum is a commonly encountered situation in clinical practice. These are mostly inserted through the rectum and occasionally, few orally ingested foreign bodies may get impacted in the rectum. Foreign body insertion in rectum is not uncommon, predominantly in males. Mostly the foreign body found in rectum are inserted with an attempt to hide illegal objects or for sexual activities.

Recent literature has indicated an increasingincidence of retained rectal foreign bodies resulting in impactionand resultant complications [4]. Patients are often reluctant toreport the presence of a foreign body, which ultimately leads to adelay in treatment due to complaints of obscure pain comprised ofstrange etiologies[5]

A variety of objects have been reported in the literature. Two-thirds of the patients are males in their 30s or 40s, who use such objects for erotic purposes.[6] It is important to know the history of similar episodes andany psychosexual behaviour abnormalities in such individuals.[7]. It is important to know the type, material, size and number of objects before attempting removal or extraction. Rectal foreign bodies are also classified as high lying or low lying, depending on their location above or below the rectosigmoid junction.[7]

Thorough history and physical examination is importatnt to rule out perforation and signs of peritonitis. Examination also includes local examination of the perineum to look for active bleeding, wounds and lacerations, followed by a DRE, if possible to look for object and anal tone. It is advisable to rule out the presence of sharp objects prior to DRE .Rectal foreign bodies may be palpated per abdominally in the lower right or left quadrant, and if high up, may not be palpated on DRE.

Clinical examination is followed by Radiological investigations. Xray Abdomen is done to look for free gas under diaphragm and also the presence of foreign body if visible. CECT is done if patient is vitally stable to look for patients which require a better characterisation of the foreign body.

Patients who are unstable or have signs of intraperitoneal rupture and peritonitis are immediately taken for Emergency Exploratory Laparotomy.Stable patients with no signs of perforation or peritonitis are taken up for transanal removal. A non-sharp palpable object less than 10 cm from the anal verge may be considered for bedside removal. Endoscopic techniques, peri-anal nerve blocks, Valsalva maneuvers, obstetric vacuums, clamps, and foley catheters have been employed to facilitate bedside removal. Transanal retrieval for distally palpable objects is initially tried under conscious sedation, or local anaesthesia or if the sphincter tone is high under spinal anaesthesia after reducing the sphincter tone. Even Endoscopic approches have become popular in the recent past.Endoscopic removal by using a flexible or rigid colonoscopy is attempted by many surgeons if the above methods fail. It is also used for removal of proximally located objects in the sigmoid or descending colon,[8] and for careful removal of sharp objects.

The following is a step wise approach used commonly for retrieving foreign body.[9]

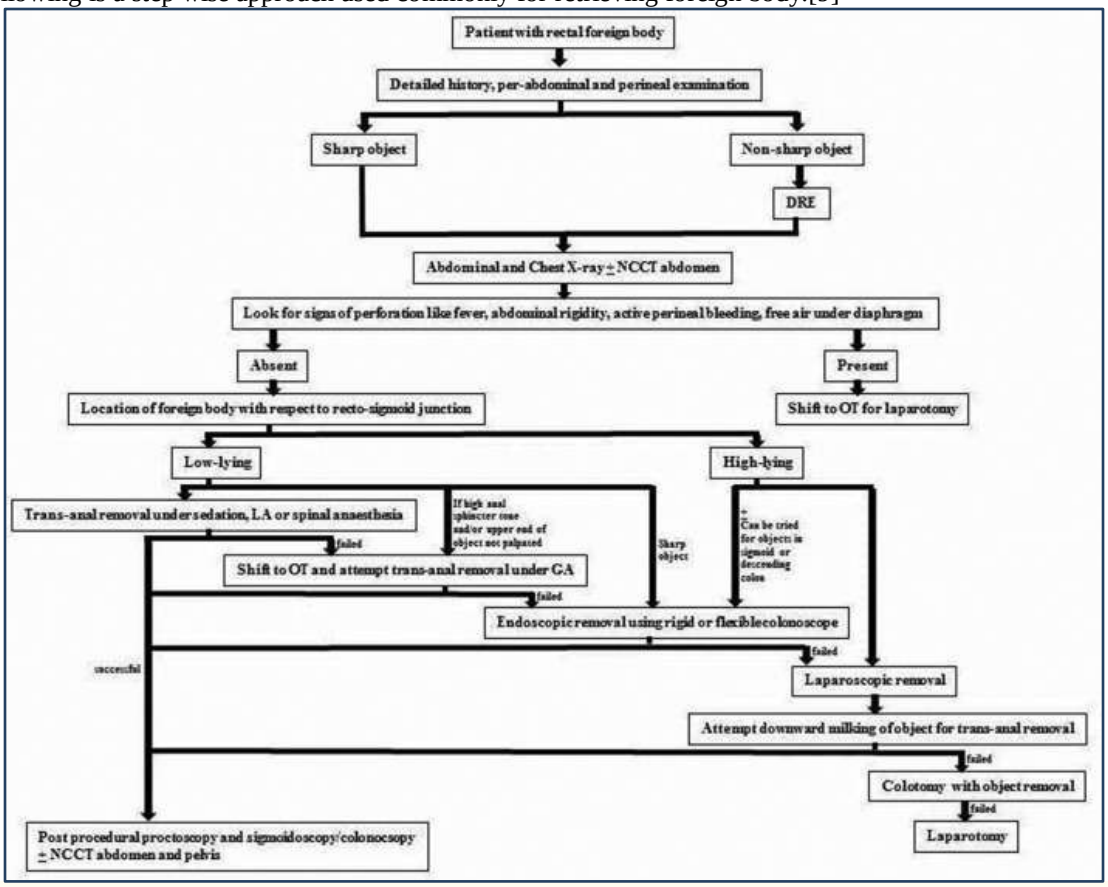


**Table 1:-** Showing Approach to patients with rectal foreign body. DRE, digital rectal examination; NCCT, non-contrast CT; GA, General Anaesthesia; OT, Operation Theatre; LA, Local Anaesthesia.

Postextraction evaluation should include a thorough endoscopic examination by proctoscopy /colonoscopy or sigmoidoscopy to rule out any mucosal injury and xray should be done to rule out perforation.Psychiatric consultation should also be compulsary in patients with voluntary foreign body insertion.

## Conclusion:-

Retained rectal foreign bodies can present as challenging clinical scenarios. Common practice utilizes a step-up approach in determining the next best step in management. Rectal forign bodies have different clinical presentations depending on shape, soze, sharpness and duration of time from insertion to hospital presentation. Local anorectal injury, intestinal obstruction, bowel perforation and peritonitis are all complications. Attempt of removal of foreign body at home can be hazardous. Manual extraction in ED should be tried first, if it fails more sophisticated intervention should be used, such as proctosigmoidoscopy, laproscopy or open surgical intervention.

Thus Nature of foreign body and Early diagnosis of retained forign body is likely to result in less invasive or non operative management.

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