ISSN: 2581 – 3633
PubMed - National Library of Medicine - ID: 101745081

International Journal of Medical Science and Advanced Clinical Research (IJMACR)

Available Online at:www.ijmacr.com

Volume – 7, Issue – 5, September - 2024, Page No. : 105 – 109

Impacted Rectal Foreign Body: A Case Report

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How to citation this article: Dr. Digant Patel, Dr. Jagrut Patel, Dr. Bharat Rathava, Dr. Prerna Razdan, Dr. Saurav Damor, "Impacted Rectal Foreign Body: A Case Report", IJMACR- September - 2024, Volume – 7, Issue - 5, P. No. 105 – 109.

Type of Publication: Case Report

Conflicts of Interest: Nil

Abstract

Introduction: Patients with foreign objects in the lower gastrointestinal tracts are uncommon. These patients present with a typical diagnostic conundrum for the attending surgeon as the typical history given by the patients is also distorted. The surgeon should consider psychiatric illness, abusive and sexual perversions also in these set of patients.

Case Presentation: An 80 years old male presented with bleeding per rectum since 6 hours and impacted foreign body which he himself inserted to stop bleeding. Patient was vitally stable and was unable to remove the foreign body by conscious voluntary effort of voiding.

Discussion: Proper history after taking the patient in confidence to know about the object and mode of insertion and duration and nature of complaints helps in management. Simple conscious effort by patients followed by the digital exploration and attempt of removal followed by endoscopic approach is the sequence followed usually. After all the above methods fail, use of anaesthesia to relax sphincter and removal is attempted or followed by laparotomy as a last resort. The patient should be also counselled to prevent any similar incidences in future.

Conclusion: Patients presenting with such complaints warrant full investigative work up because what may seem a simple impacted object in the gastrointestinal tract may cause perforation and peritonitis if not diagnosed and treated properly. The foreign body was removed after giving anaesthesia and a diversion procedure was done in this case followed by closure.

Keywords: Foreign body, gastrointestinal tract, potato

Introduction

Foreign bodies in the lower gastrointestinal tract can be due to oral ingestion of the foreign objects which remain undigested and negotiate through the gastrointestinal tract to reach the lower part of the gastrointestinal tract, or more frequently due to insertion of the objects from the anal opening. The reasons can be from accidental ingestion of the foreign body orally to purposeful insertion of the foreign bodies either by self or others via the anal canal. Objects can be inserted for diagnostic or therapeutic purposes, or self-treatment of anorectal disease, by criminal assault and accident or, most commonly, for sexual purposes[1]. The patients with foreign bodies may come to seek medical attention only after they develop symptoms as asymptomatic foreign bodies may prevent patient from seeking treatment due to embarrassment. Most patients with rectal foreign bodies present to the emergency room usually after efforts to remove the object at home[1]. The management of patients in this scenario should include careful elucidation of the events leading to the foreign body at its position during presentation. This should include detailed history taking, keeping in mind the sensitivities of the individual as the patient may be apprehensive or ashamed due to the location of the problem or patient may be suffering from a psychiatric disorder.

The management of these patients include attempts to remove the foreign objects via anal opening without and with anaesthesia. If these attempts fail, the patient requires exploratory laparotomy for removal of objects and repair of any damage due to the foreign body.

Patient Presentation:

An 80 years old male presented in the emergency department at around 3:00 A.M. in morning with

c/o – bleeding per rectum since 6 hours,

c/o – impacted foreign object in the anal region

c/o – external haemorrhoids since 3 years

The patient had no history of fever or pain. the patient gave history of spontaneous bleeding per rectum to stop which the patient inserted a potato per rectally.

Patient had no history of spontaneous bleeding in the past and he had no complaint of pain in abdomen, fever, diarrhoea, straining during stools.

Patient is also not a known case of any medical illness and has no history of addiction.

Clinical Findings

The patient on presentation was vitally stable.

Abdominal examination revealed no pain or tenderness in abdomen.

Bowel sounds were audible.

On rectal examination- anal tone was normal. The foreign body was felt on the tip of the fingers approximately 8 cm from the anal verge and felt as object with smooth contours and felt ovoid.no active bleeding was present. Fingers were stained with blood.

Proctoscope examination revealed multiple lacerations in the anal canal whose exact dimensions couldn't be assessed due to the foreign body.

Rest of the examination was uneventful.

Investigations

The patient was vitally stable. Blood was sent for standard workup including haemoglobin, total white blood count, platelet count, Prothrombin time and International Normalized Ratio (INR). The patient was sent for erect x ray chest and abdomen and pelvis with bilateral hips, followed by ultrasonography of the abdomen.

All the investigations were within the normal reference range and revealed no abnormality. X rays of abdomen were not suggestive of foreign objects.

Therapeutic Intervention

Per rectal lignocaine jelly application was applied generously and patient was asked to attempt to void to remove the foreign object spontaneously and with valsalva.

The foreign body could not be removed after conscious voiding effort by the patient.

Patient was put in left lateral position and attempts were made to remove the foreign body manually with fingers, but couldn't be completed due to lack of adequate grip on the object.

Patient was kept in left lateral position and Proctoscope was re inserted and obturator of the proctoscope was removed and the foreign body visualized after 10 cc normal saline push in the proctoscope. The patient was shifted to the operating room and put in lithotomy position and short General anaesthesia was given and the foreign body was palpated and extraction was done after applying two retractors on the anal canal and passing Langenbeck retractor beyond the impacted object. The object was a potato of size 9 cm by 7 cm and approximately ovoid in shape.

After the removal of the potato, patient's anal canal was examined with proctoscope and multiple lacerations were found in the anal canal, largest of size 7 cm by 3 cm involving mucosa, submucosa, muscularis and serosal layers extending from 3 o clock position to 5 o clock position. Another tear was found at 9 o clock position to 11 o clock position of size 4 cm by 1 cm involving mucosa, submucosa, muscularis and serosal layers. A third tear was seen at 12 o clock position to 1 o clock position of size 4 cm by 1 cm involving mucosa , submucosa, muscularis layers.

Immediately the decision was taken to do primary repair of the multiple lacerations and a diversion sigmoidostomy was planned. The patient was given general anaesthesia and multiple lacerations were repaired with absorbable sutures and absorbable haemostatic gelatin sponge was kept per rectally.

Sigmoid loop colostomy was done and an abdominal drain was kept in the left side in the pelvis.

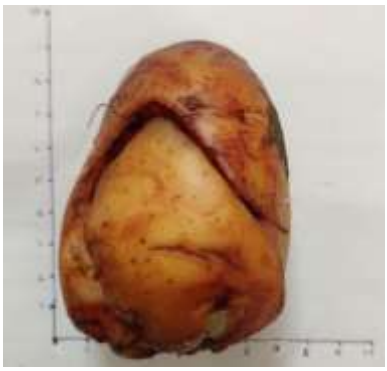

Figure 1: Removed foreign body, a potato of 9 cm by 7 cm size.

Follow–Up and Outcome

The absorbable sponge was removed after 24 hours and patient's stoma started functioning after 24 hours. Per rectally bisacodyl suppository tablets were kept to empty the distal loop to prevent further soiling of the sutured lacerations. A combination of metronidazole along with mupirocin ointment was applied on the sutured lacerations twice daily.

The opinion of a psychiatrist was taken for the patient , but the patient denied any history of voluntary insertion of foreign objects except the potato, which he did to stop the bleeding.

The drain was removed after 5 days when output decreased to nil in previous 24 hours.

The patient's stoma site suture line healed and all the sutures of abdomen incision were removed on 14 day

and maturation sutures and spigot was removed just before discharge.

The patient was discharged on 15th post-operative day after consulting a psychiatrist again before discharging.

After a period of 3 months the distal loopogram was done and after confirming patency of distal loop, sigmoidostomy closure was done.

Patient came for follow up and was well upto the last follow up which was after 4 weeks of sigmoidostomy closure.

Discussion

This is a rare case report of impacted foreign body in a very old patient. Though the patient himself inserted the object in rectum, the reason of insertion of the object doesn't correlate with the lacerations in the rectum. Foreign body in the rectum is becoming more common. [2]. Males are involved more than females. [2].

There is a bimodal age distribution, observed in the twenties for anal erotism or forced introduction through anus, and in the sixties mainly for prostatic massage and breaking faecal impactions [3].

Not all the patients present immediately after insertion of the foreign body. Some may present long after insertion of the foreign body only when they develop symptoms. The longest time described in literature is a patient presenting about 5 years after insertion of object in rectum.[4] The rectal location of the foreign body prevents the people from consulting a medical professional as it's embarrassing.

They may complain of vague abdominal pain, rectal bleeding or pain and sometimes constipation [3]. Some patients are asymptomatic at presentation. The history of events leading to foreign object in rectum given by the patients is often incorrect with patients hiding the actual mode and events.

Per rectal examination is the keystone in the diagnosis, but it should be performed after X-ray abdomen to prevent accidental injury to the surgeon from sharp objects. [5].If the patient is vitally stable, then the patient is subjected to x ray of chest in erect position and x ray of pelvis with bilateral hips in antero-posterior and lateral views. After that, ultrasonography of abdomen and pelvis is done.

X rays reveal if there is any radiopaque object present. Erect x rays rule out free gas under diaphragm which rules out perforation. Patient may have some signs of obstruction on the radiographs.

Techniques for extraction are determined according to the size, placement height and structure of object. For objects placed on the rectosigmoid junction, the possibility of being passed into the rectum and transanal extraction should be assessed. Foreign objects under the rectosigmoid junction must be assessed according to the breakage risk and determined if they have sharpened surfaces. [4]

This is followed by per rectal examination of the patient. The location , shape , consistency of the impacted object may be felt during rectal examination. This is followed by attempts to remove the foreign body by digital manipulation. The next step is the insertion of an endoscope with subsequent attempts to grasp the foreign body with regular endoscopy accessories like polypectomy snares.[1] Even if this also fails then the patient is taken to the operating room and patient is given anaesthesia to fully relax the sphincters and decrease the pain .

Use of a perianal block and conscious sedation helps in better relaxation of the anal sphincter, increasing the chances of successful removal. Additionally, suprapubic pressure applied by an assistant helps in pushing the

object caudally. In awake patients, having them perform the Valsalva maneuver works in the same manner.[6]

Laparotomy is only required in an impacted foreign body and/or with perforation peritonitis. Even with laparotomy, the aim is transanal removal and closure of perforation with diversion colostomy.[5] After successful extraction of the object the patient is subjected to repeat x rays to see leftover radiopaque objects. A colonoscopy is planned and barium enema is given. All these help in determining if the integrity of the bowel is maintained or patient has some other injuries.

If there is perforation, peritonitis, deep lacerations, then to avoid contamination, diversion procedure is advocated. This allows adequate time for healing of the injured part.

Patients should be consented for a laparotomy prior to general anaesthesia should the manual or endoscopic removal fail.[1]

Traumatic disruption of the anal sphincter can result in mild to severe faecal incontinence, depending on the degree of the injury. Attempts for surgical correction of any sphincter injury should be delayed until adequate time has passed to evaluate any resultant defect and clinical symptoms.[7]

The psychiatrist is consulted and his opinion is taken to rule out any psychiatric disorders and inappropriate tendencies and behaviours by the patients.

Conclusion

Impacted foreign bodies in the rectum are uncommon but the number of cases is increasing with significant male preponderance. Management included evacuation of the object under anaesthesia along with a temporary diversion procedure with closure of the stoma after some time. Patients may be hesitant to share details of the incident so clinicians may need to treat such cases just based on investigations and examination findings.

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