



POSTOPERATIVE IMPACTION OF FOREIGN BODY IN RECTUM FOLLOWING ANORECTOPLASTY

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ABSTRACT

Foreign body ingestion in the pediatric age group is not rare. Retention of a foreign body at the anorectal junction in the pediatric age group is very rare. This case of 5 – year – old male child presented with a history of constipation requiring on & off dilatation. Skiagram was suggestive of anorectal stenosis. The child was operated for high anorectal malformation. Anoplasty revealed a foreign body from the anorectal junction. The child was discharged after treatment and has an uneventful follow up.

KEYWORDS: Anorectal Malformation, Foreign Body Rectum, Anoplasty, Complications of Colostomy.

INTRODUCTION

Foreign body ingestion is very common in the pediatric age group. The most common foreign body ingested by children is a coin, small parts of toys, safety pin. The commonest site for the impaction of the foreign body in the gastrointestinal tract is the upper esophagus mostly in the cricopharynx which can be removed endoscopically. Retained or impacted foreign body at the anorectal region is more common in adults & sometimes needs surgical intervention for retrieval. Rectal impaction of foreign body is rare in pediatric patients. We report a case of several foreign bodies being retrieved from the rectum of a 5 year old male child who was operated for anorectal malformation.

CASE REPORT

A 5-year-old male child was referred to our hospital with a history of intermittent constipation for 5 months. The child was a known case of hemophilia. Birth history revealed absent anal opening at birth for which, sigmoid colostomy was done at day 3 of life. Subsequently posterior sagittal anorectoplasty and colostomy closure was done at 13 months & 18 months respectively. Patient was on regular follow up and was also kept on regular dilatation schedule starting 2 weeks following surgery. The child was examined at our hospital & on general examination found to be normal. Digital rectal examination revealed obstruction at anorectal junction confirming a diagnosis of anal stenosis/ anal stricture.

Radiography revealed a dilated rectum with radiopaque shadows at the anal region (Figure 1).



Figure 1: Contrast radiography.



Figure 2: Foreign body retrieved.

The child had undergone anoplasty and a button of size 1.5 cm X1.5 cm along with a glass ball of size 1X 1 cm was removed (Figure – 2). Child had an uneventful postoperative recovery. Patient is doing well at 6 months follow up

DISCUSSION

Ingestion of foreign body in the pediatric age group is very common & is most commonly seen in 6months to 5 years of age.^[1] A foreign body is usually retrieved in the stool of the patient if it passes into the stomach. Reassurance and watchful observation is practised if the foreign body is not likely to cause any complication. However, some ingested objects may cause bowel perforation, gastrointestinal bleeding, obstruction, requiring immediate management to prevent further complications.^[2] Very few needed surgical removal.

Despite of following a dilatation schedule for 6 months the patient had developed an anal stricture. Such complication following dilatation has not been reported in literature. As the dilatation was a domicile-based intervention, assuring the cooperation of the caregivers and following the schedule is questionable. We could not find any follow up records of the patient during the dilatation program which reiterates the fact that dilatation was not carried out properly resulting in anal stenosis.

The digital rectal examination during the follow up of patients undergoing anorectoplasty can't be overemphasized. The anal stenosis could have been diagnosed earlier and appropriate intervention would have averted the prolonged constipation of the patient.

Anal stenosis following treatment for high ARM is seen in 14-38% of cases.^[3] The patient had impaction of foreign body in the rectum as he was having anal stenosis following anorectoplasty performed for ARM. Similar complication has also been described by other authors.^[4] The possible source of the foreign bodies may be ingestion following colostomy closure or insertion through the distal loop of the sigmoid colostomy. While the patient was on colostomy since it was a loop colostomy he might have inserted the foreign bodies into the distal colon. As the patient developed anal stenosis he could not pass the foreign bodies per anum. The anoplasty had dilated the canal and helped in retrieval of foreign bodies. All stages of anorectoplasty including colostomy closure should be completed during infancy. As the patient was carried on with colostomy till 18 months of age the insertion of foreign body into the distal colon remains a possibility. Earlier completion of all stages also has an advantage of the child having a cognition of toilet training as natural as possible.

CONCLUSION

Anal stenosis and stricture are a few of the known complications following surgical procedures done for ARMs. Failure to pass foreign body through anal canal

due to anal stenosis, occurring postoperatively, after high ARM correction is very rare.

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