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Case Study

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FOREIGN BODY IN RECTUM PRESENTING WITH INTESTINAL OBSTRUCTION

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ABSTRACT

The diverse collection of foreign bodies that have been found in the rectum is hardly less remarkable than the innovative means adopted in their removal. It is difficult to create a vacuum effect when trying to extract the foreign body from the rectum through the anus. Laparotomy is usually necessary when there is difficulty in grasping the foreign body in the rectum. We report a case of an adult male who presented in the emergency department with an incarcerated, large, neglected rectal foreign body, a 'stainless steel glass, and causing intestinal obstruction. Emergency laparotomy was required for its removal.

KEYWORDS: Foreign Body (FB), Rectum, Laparotomy.

INTRODUCTION

Large bowel obstruction (LBO) is defined as a mechanical or functional obstruction at the level of colon or rectum, not allowing the natural passage of the products of digestion.[1] It typically occurs in the elderly and requires prompt medical or surgical treatment. The urgency of management is driven by the risk of rupture in the distended or compromised colon with the danger of faecal peritonitis.[2]

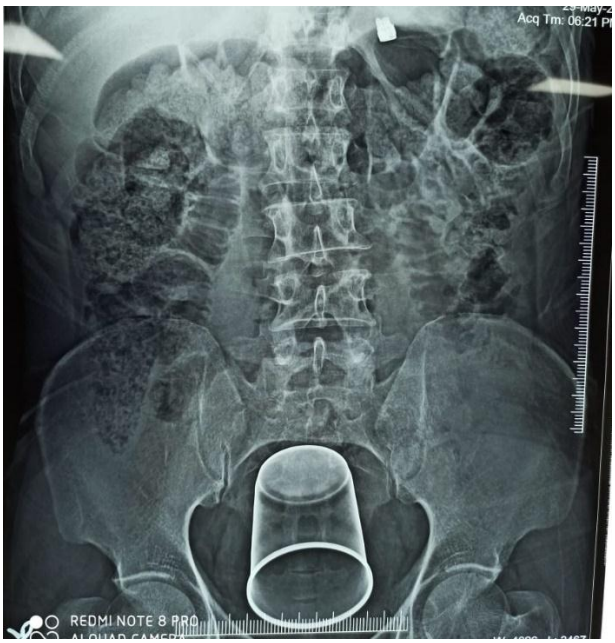
Typical clinical features of LBO are: abdominal pain due to distension and colic; abdominal distension due to retention of faeces and flatus; constipation; non-passage of faeces or flatus (signifying complete obstruction); peritonism (if perforation has occurred) and vomiting.[3] Colorectal foreign bodies are infrequently encountered, and are mostly associated with increased incidence of homosexuality and anal auto-erotism. The diagnosis may be confirmed by plain abdominal radiographs and rectal examination, but abdominal computerized tomography can be decisive in the further management. Manual extraction is only possible for very low-lying objects; patients with high-lying foreign bodies usually require a major intervention in the operation theatre. An early decision of laparotomy should only be made after subjecting the patient to suitable investigations to determine exactly the localization of the object, in order to avoid any inadvertent damage to the adjoining vasculature as well as anal incontinence.[4]

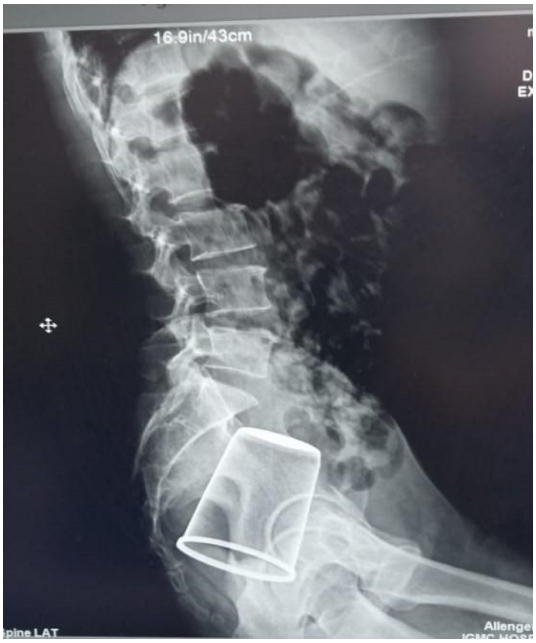
CASE REPORT

A 47-year-old male patient presented to us with complaints of pain involving the whole abdomen for 3 days with non-passage of flatus and stools for 2 days. Pain was insidious in onset, mild to moderate in intensity, generalized, continuous and gradually progressive. He also had complaints of non-passage of flatus and stools for 2 days associated with abdominal distension and multiple episodes of bilious vomiting. There were no associated aggravating or relieving factors. There was no history of melena or previous abdominal surgery. He had no associated comorbidity. His vital parameters were within normal limits. On per abdomen examination, the patient was found to be having generalized tenderness all over the abdomen along with guarding, rigidity and rebound tenderness. There was no organomegaly or palpable lump. Hyper tympanic note was present on percussion with obliterated liver dullness. Bowel sounds were absent.

Blood investigations were as follows: Hb -16.4g/dl, TLC – 8,700mcg/L, Urea - 77 mg/dl, Creatinine - 1.1mg/dl, Na -133 mmol/L, K - 3.2 mmol/L, Bil(T) – 1.95mg/dl, Bil(D) – 0.96mg/dl, ALT/AST/ALP – 78/68/96 U/L, Lipase/Amylase – 56/47 U/L.

His abdominal X-ray revealed multiple dilated gut loops with impacted fecal matter suggestive of large bowel obstruction with a cylindrical radio-opacity in the pelvis suggestive of an impacted foreign body. Note was also made of kypho-scoliotic deformity of the spine.

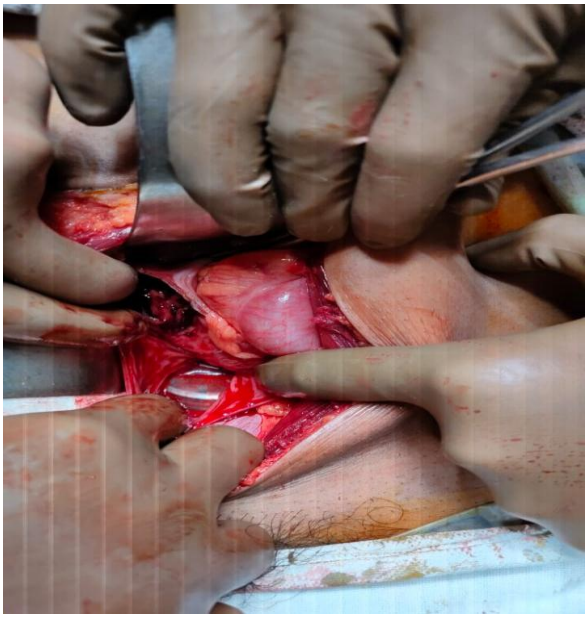


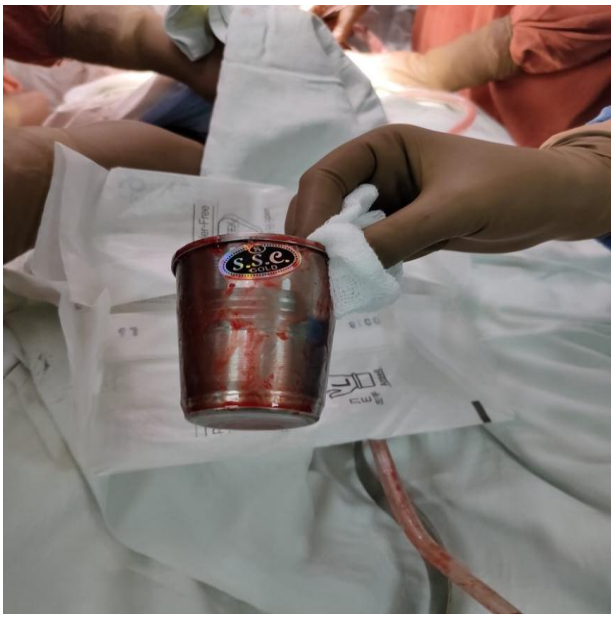


A diagnosis of acute intestinal obstruction due to impacted rectal foreign body was made and the patient was taken to the operation theatre for exploratory laparotomy and further management.

Intraoperative findings

An initial unsuccessful attempt at transanal extraction of the rectal foreign body under local anaesthesia with conscious sedation was done. Decision was made to proceed with emergency laparotomy. Lower midline laparotomy incision was given. Large bowel loops were found to be distended. There was no evidence of free fluid. A hard, cylindrical structure of size approximately 10cm X 7cm was palpated at the rectosigmoid. Again, an attempt was made to push the object from above into the assistant's fingers in the rectum but it was too wide to cross the pelvic brim. A rectotomy was performed anteriorly in the proximal area of the rectum and a cylindrical, stainless-steel glass was extracted. A primary repair was done and the abdomen was closed after careful inspection of rest of the gut.





Postoperative period was uneventful. The patient was continent and had no problems in defecation.

DISCUSSION

Colorectal foreign bodies are infrequently encountered. Their presence is usually indicative of homosexuality, auto-erotism or a mentally unstable individual. Removal of retained foreign bodies can be a tedious process, requiring considerable skill and ingenuity on the part of the surgeon.[5-8]

The main reasons for the presence of foreign bodies include pruritus ani, accidental insertion, alleged assault, drug smuggling, iatrogenic (e.g., migration of colonic stents), and psychosexual motives[9]. A wide variety of objects have been noted in the literature, including bottles, vibrators, fruits and vegetables, tools, and miscellaneous items such as light bulbs, candles, balls, and flashlights.[5,6,9-12] The management of these cases varies from simple manual retrieval with or without general anaesthetics or use of a sigmoidoscope, Foley's catheter or even cyanoacrylate adhesive attached to the object in order to aid its removal.[5,13]

A "stainless-steel glass" as the rectal foreign body is quite rare. Moreover, a rectal foreign body presenting further as bowel obstruction is an even rarer phenomenon. In this case, as the cylindrical glass was large and impacted high in the rectum, any manipulations through the transanal route could have caused rectal perforation or injury to the sphincter, with prolonged complications. Thus, a decision for emergency laparotomy was taken and the glass was removed without any complication.

CONCLUSION

Rectal foreign bodies are quite uncommon; however, most general surgeons will encounter such a patient at some point in their career. The diagnosis may be confirmed by plain abdominal radiographs and rectal examination, but a three-dimensional, abdominal CT can be decisive in the further management. Manual extraction is only possible for very low-lying objects; patients with high-lying foreign bodies usually require a major intervention in the operation theatre. An early decision of laparotomy should be made only after subjecting the patient to suitable investigations in order to accurately localize the foreign body.[4]

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