

Removal of an impacted rectal foreign body - avoiding laparotomy

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Introduction

Insertion of foreign bodies (FB) into the rectum accidentally or voluntarily for sexual enjoyment has been reported since the 16th century [1]. The true incidence in our population is unknown as many cases are unreported due to the nature of the condition [2]. Abraham et al reported that there is an increase in incidence of rectal foreign bodies presented to the emergency departments in the United Kingdom [3]. Patients normally seek medical attention when attempts at self removal fails at home. We report a 48-year-old male who presented with a rectal FB which led to constipation and abdominal distension.

Case presentation

A 48 year old male was referred to the general surgery team for an impacted rectal FB with constipation and abdominal distension for three days. Further history revealed a voluntary insertion of a foreign body for sexual pleasure with failure of removal. Physical examination revealed no signs of peritonism with a mildly distended abdomen. On per rectal examination, a hard plastic mass was felt which was lodged firmly in the lower rectum. Attempts at bedside transanal



Figure 2: Successful trans-anal removal of a vibrator after induction with general anesthesia and muscle relaxation.

extraction with sedation failed. Abdominal radiograph (Figure 1) showed a longitudinal mass lodged in the upper to lower rectum without any evidence of pneumoperitoneum. Endoscopic removal using a snare-wire also was unsuccessful and hence, operating theatre was booked for removal of rectal FB under general anaesthesia. Following induction of general anaesthesia, the lax abdomen (effect of muscle relaxant) allowed gentle manipulation of the FB over the suprapubic region which helped with successful transanal removal (Figure 2). Approximately six hours post removal, the abdominal pain and distension resolved. There were no signs of peritonism and vital parameters remained normal. However, the patient was discharged on his request despite being informed of potential post-operative complications such as bowel perforation, laceration and anal sphincter injury. The patient also refused subsequent psychiatry and general surgery follow up visits.

Discussion

Although there are no exact figures, an increasing trend in incidence of retained rectal FB is reported [1]. Malaysia, a multi racial, Asian country which is still considered a conservative nation is of no exception. Sexual gratification is the most common reason for rectal insertion of FB [2]. Due to the nature of the condition, many cases go unreported to avoid embarrassment. An urgent explorative laparotomy after adequate fluid resuscitation is mandatory for patients with positive peritonism or pneumoperitoneum on abdominal

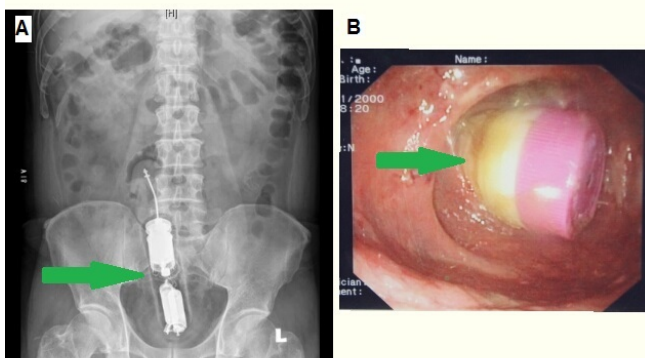


Figure 1: A. Abdominal radiograph showing an impacted rectal foreign body (arrow); B. Failed colonoscopic removal of the foreign body.

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radiographs. If there no evidence of bowel perforation several techniques of extraction may be attempted. Bedside trans-anal extraction has been reported to be successful in 60-75% of cases [4]. Endoscopic extraction with snare wire may also be attempted which however may not be successful as seen in our case, due to the size of the FB and its shape which prevented an adequate grip with the snare-wire. In this reported case, the rectal FB was removed only after induction of general anaesthesia with muscle relaxation. Muscle relaxation allowed for gentle pressure on the suprapubic area in lithotomy position, which allowed manipulation of the FB towards the anus and successful delivery of the plastic vibrator device. Decision for a non-operative method of removal initially was attempted as there were no signs of peritonism or pneumoperitoneum on abdominal radiograph, and patient had stable vital parameters.

In 2013, a similar case of a lodged vibrator in the rectum with failed removal under general anaesthesia was reported by Sanger et al (1). This case was treated in a Malaysian government hospital and was removed via a laparotomy and a sigmoid colotomy which was primarily repaired. In cases of trans-anal removal, patients need to be followed up for signs of incontinence from anal sphincter injury. More importantly, a referral to a psychiatrist may be necessary to establish the motivation for FB insertion, which is important in prevention of further occurrences. Apart from sexual gratification, psychiatric illnesses (borderline personality disorder, psychosis with or without mood disturbance, factitious disorder and depressive disorders with psychotic features) are also known to predispose to such FB insertions and hence, a referral to a psychiatrist will help with these aspects [5].

This case report, highlights the occurrence of such cases in Southeast Asian countries which requires an increase in awareness among Surgeons on management options and implications. It is difficult to quantify the occurrence of such cases due to the embarrassing nature of the event where most instances would remain unreported. Medico-legal issues also may arise from such insertions especially if a third party had

been involved or the insertion had been performed against willful consent. Insertion for pure self-gratification still remains a grey area in contrast to insertion without consent which is legally considered assault [6].

Conclusion

The mainstay of management of a rectal foreign body is primarily the removal of the retained foreign body, preferably by the least invasive method, or by operative procedure if all other attempts at removal fails. Treatment does not end after removal and it is important to identify and treat any underlying psychiatric disorders where relevant.

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Learning Points:

- Incidence of foreign bodies in rectum is increasing and techniques of removal of these foreign bodies is of importance to surgeons, emergency physicians and gastroenterologists.
- A psychiatric assessment after removal may be important to prevent subsequent episodes.