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A Rare Challenging Case of Rectal Foreign Body Insertion

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Abstract:-

- ***Introduction:***

Rectal foreign body insertion poses diagnostic and management challenges, often linked to sexual activities, with significant complications possible.

- ***Presentation of Case:***

A 21-year-old male inserted an iron rod through his anus to relieve constipation. Examination revealed no visible anal injury or complications, although he experienced abdominal pain and had mild intellectual disability.

- ***Clinical Discussion:***

Rectal foreign bodies, often inserted for sexual gratification, pose serious risks. Common among intoxicated individuals, they can cause blockage, bleeding, and pain. Rectal examinations are vital for diagnosing foreign bodies but require imaging to prevent injury. Prompt treatment is essential to avoid serious complications.

- ***Conclusion:***

Managing rectal foreign bodies can be challenging. A systematic approach is essential, with most cases treated conservatively; surgery may be needed for large, embedded objects.

I. INTRODUCTION

Rectal foreign body insertion is a clinical situation that presents special difficulties in diagnosis and management. Rectal foreign body is an uncommon finding, frequently connected with sexual delight, rape or the consequence of ingestion and seldom unintentional, and are on increasing incidence.1 They are generally normal in the metropolitan population and for the most part found in people of the third and fourth decades.2 Earliest case reports of rectal foreign body date back to the sixteenth century.3 The management of an foreign body in the rectum is frequently provoking for a specialist because of the variety in time of insertion, related wounds, and type and area of an object.4 The show might go from asymptomatic to intense abdominal pain, and patients might be hesitant to tell the reason because of shame or apprehension about legitimate ramifications. The difficulties related with rectal foreign bodies can be huge, including rectal perforation, dying, disease, and peritonitis. Exact diagnosis through clinical history, actual assessment, and imaging reads up is fundamental for effective management. Treatment frequently requires a multidisciplinary approach, remembering careful mediation for extreme cases.

We present a case of a rectal foreign body, the nature and shape of which made the identification and removal even more challenging.

II. CASE REPORT

A 21-year-old unmarried male presented to the emergency department with an alleged history of self insertion of a iron rod through the anal opening 2 hours ago. He admitted purposeful insertion to pass stool since he had not passed stool for three days but was passing flatus, and there was no abdominal distension. It was associated with lower abdominal and rectal pain but no per-rectal bleeding. He had tried to remove the rod himself but had been unsuccessful. There were no comorbidities, and the patient has mild intellectual disability which was confirmed on psychiatric evaluation. The patient's mood, behaviour patterns, and insight were normal at the time of examination.

On physical examination, the abdomen was soft and non-tender, the foreign body was not palpable, and there were no signs of peritonitis. On digital rectal examination (DRE), there was no anal injury or bleeding, and the anal tone was intact, lower end of the rod could be seen through the anal opening.

The patient was admitted and investigated. The preoperative investigations were within normal limits. An erect abdominal X-ray showed a foreign body resembling a rod like structure with curved end in rectum and sigmoid but no pneumoperitoneum was noted.

The patient was taken inside inside operation theatre and kept in a lithotomy position and manual removal of foreign body was attempted via anal opening, but the procedure was averted as the rod could not removed and as there was a significantly high risk of injury which could, in turn, lead to injury to the bowel or to the intact anal sphincter complex.

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So, exploratory laparotomy was performed through a lower midline incision and sigmoid colon and rectal perforation was noted. The rod was removed and the primary closure of perforations were done along with tranverse colostomy and a pelvic drain was kept. The post-operative period was uneventful. On the first postoperative day, stoma of patient was functioning and a liquid diet was started. A drain was removed on the 16th postoperative day and the patient was discharged on the 17th postoperative day. On regular follow-up, patient had no post op compiliacations and intact anal tone and after three months patient was again admitted and stoma closure was done and post op period was uneventful.

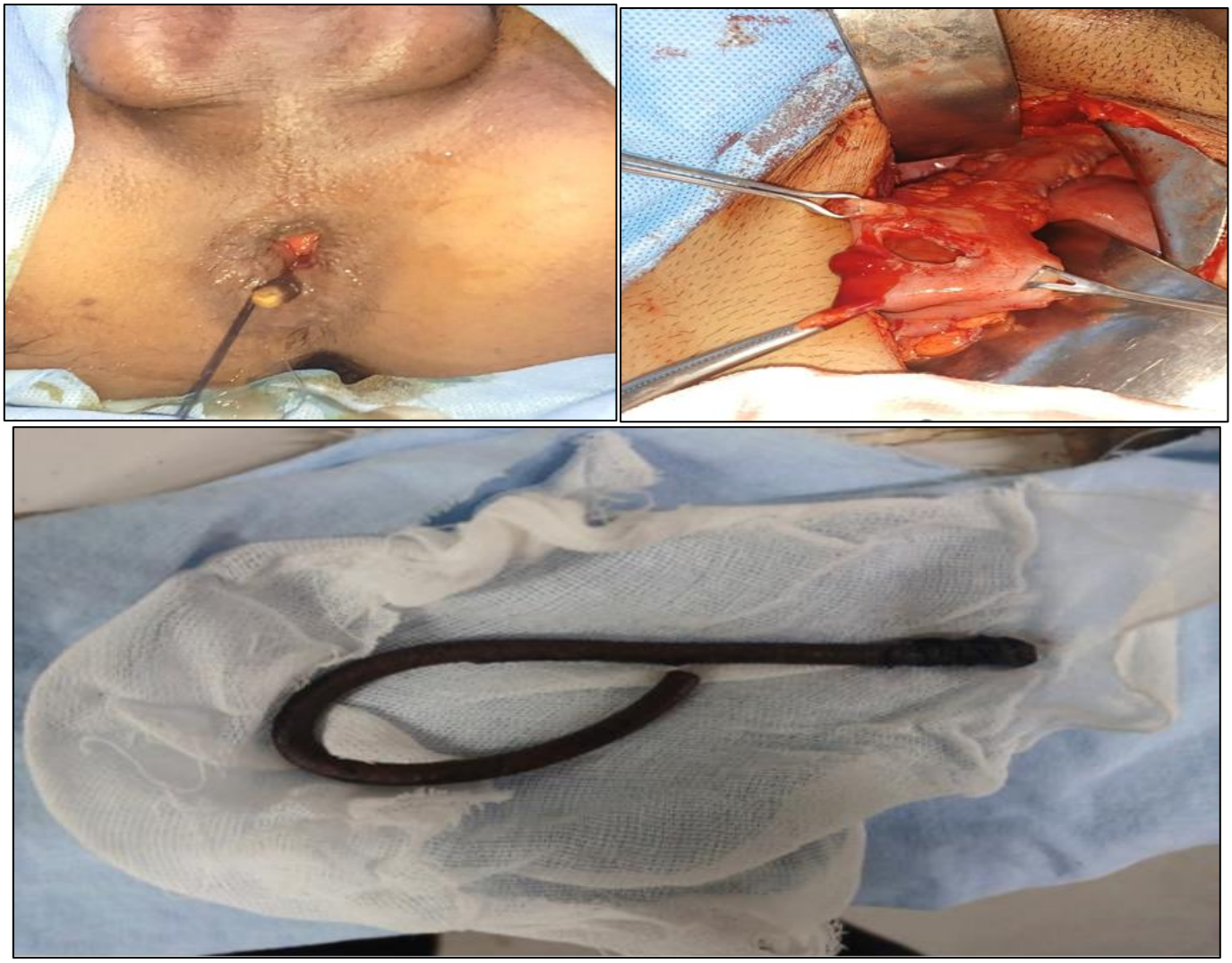

Fig 1: Case Reports

III. DISCUSSION

Rectal foreign bodies have been the subject of numerous case reports. Bottles made of plastic or glass, soda or beer bottles, containers for deodorant, wooden or rubber objects, and household items have all been reported as having been inserted. The purposeful insertion of a foreign body for the purpose of sexual gratification in unnatural sexual behavior was found to be the most common cause of a foreign body in the rectum1. The majority of patients are typically under the influence of alcohol when the foreign body is inserted. In addition to sexual activity, rectal foreign bodies are typically found in children, the elderly, and psychiatric patients6. Body packing, also known as rectal foreign bodies, is also common among drug traffickers. All of these things should be treated as dangerous because they could seriously hurt the rectum. Our patient had a mental illness and had an iron rod inserted to relieve constipation.

The most typical presentation is sub-acute intestinal blockage. After several efforts at self-removal, the patient typically presents with constipation, per-rectal hemorrhage, and stomach pain. Embarrassment generally causes presentations to be postponed.5. In the event of a perforation, these individuals may exhibit sepsis-related symptoms in addition to fever, vomiting, and excruciating abdominal pain. Parenteral hydration and broad-spectrum antibiotics are recommended in such complex instances (resuscitation) together with an urgent exploratory laparotomy.5. Our patient arrived at the hospital early, and no serious complications had yet to arise.

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Rectal examinations are essential for diagnosing rectal foreign bodies, but they should only be performed with appropriate abdominal imaging to rule out the existence of sharp items and avoid unintentional injury.6 While computed tomography (CT) scans are occasionally required to rule out problems (intestinal perforation), X-rays of the abdomen and pelvis aid in localizing the foreign body.7. Due to their delayed manifestation, a wide range of rectal foreign bodies can cause serious harm, from mucosal damage to intestinal perforation, which makes diagnosis and treatment challenging and can result in sepsis and death.10. In order to alleviate symptoms and avoid consequences, these patients need immediate measures. Excluding the related injuries and consequences is also crucial. Even though our patient did not have sepsis, things would have likely turned out differently if there had been any more delay.

For the purpose of extracting foreign bodies, many different methods are employed. Selecting the best extraction technique is frequently challenging.5. Approximately 35–40% of individuals with related injuries and consequences require immediate surgical excision. Its location, size, and shape all affect how it is managed.2. The transanal technique can remove between 60 and 75 percent of the rectal foreign materials.5 I When endoscopic or transanal removal is unsuccessful, or if problems such bowel perforation arise, a laparotomy is recommended.8. If an object presents close to the rectum and cannot be removed within 24 hours, laparotomy is the main treatment option.8. In our instance, the transanal strategy did not work, therefore we converted to open abdominal surgery.Rectal foreign bodies may move to the next organ as a result of delayed presentation.9. The ileocecal valve, anus, appendix, and cecum may become obstructed.4. Poisoning could result from absorbing deteriorated material. Bowel perforation, which results in sepsis and death, is the most terrible consequence.

IV. CONCLUSION

It can be difficult to manage people who have rectal foreign bodies. A methodical strategy is suggested to steer clear of problems. While most cases can be effectively treated conservatively, the odd trip to the operating room for removal assisted by laparoscopy or celiotomy may be necessary. Pubic symphysiotomy should be taken into consideration when there are huge, securely embedded things that are impossible to remove, even with an open abdomen.

CONSENT

Informed consent was obtained from the patient for publication of this case report and accompanying images.

- Ethical Approval: The approval of our institutional ethics committee is unnecessary for a clinical case report.

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