

An Interesting Case of ANO-Rectal Foreign Body

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Abstract: Autoerotic activity with rectal foreign body leading to ano-rectal injuries has been reported in various literatures. The object in such an instance, was a health faucet, which was extracted under spinal anesthesia.

Keywords: Foreign body, ano-rectum, sexual perversions, unnatural sexual offense, shower bidet, health faucet, ano-rectal injuries.

Date of Submission: 27-02-2019

Date of acceptance: 14-03-2019

I. Introduction

Rectal foreign bodies have been earlier reported^{1,2}. They are either orally ingested or anally inserted. The most common cause of foreign body insertion are unnatural sexual practices, trauma and psychiatric disorders. Rectal foreign bodies inserted in the rectum per anally are noted most commonly in middle-aged men/homosexual males^{3,4}. Managing rectal foreign body is a challenge and there are various techniques to remove these impacted foreign bodies. Here, we report a patient admitted to the emergency department with rectal foreign body relating to autoerotic activity managed with meticulous surgical removal.

II. Case Report

A 22-year-old man had inserted a bidet shower in to his anus for sexual arousal. Afterwards he tried to extract it out but to no avail. He then presented to the ER with complaints of pain at anal region with no history of vomiting, abdominal distention and guarding. On examination, there was tenderness at the peri-anal region with no active bleeding per-rectally. Bowel sounds were normally heard on auscultation. The severed end of the pipe which was attached to the end of the health faucet was palpated per rectally and the upper end of the object could not be felt.

On investigation, X-ray abdomen with pelvis showed foreign body inside the pelvis with no signs of perforation. Other laboratory investigations were normal - Hb: 13.2%, TLC: 7400 cells/cu.mm

The patient was then taken up for surgical removal of the impacted object under spinal anesthesia. On exploration, the health faucet was found in the anal canal extending around 6cms into the lower rectum [Fig1]

The foreign body was carefully retrieved trans-anally after exploration.

Primary closure of mucosa and submucosa for approximately 10 cm from the anal verge at 3'o clock position was then performed [Fig2].

The postoperative period was uneventful. Psychiatric consultation was given for the patient. He was discharged after 4 weeks with advice to follow up in surgery and psychiatry OPD, patient was then doing well during his follow up visits.

III. Discussion

Foreign bodies can be inserted anally. They are mostly demonstrated in middle aged homosexual men^{3,4,5,6,7}. The various kinds of rectal foreign bodies are glasses, cans, jars, umbrellas and vegetables⁸. Drugs to treat itching, constipation, haemorrhoids or rectal prolapse can be inserted into the rectum and it remains there⁸. These reported incidences of rectal foreign body insertion have been increasing^{6,7}. There are a variety of management options of anorectal injuries.

The patients present with abdominal or pelvic pain, tenesmus, obstipation and rectal bleeding⁸. When the patients frequently try to take the objects out themselves, they may cause the objects to displace more proximally leading to rectal injury⁹.

Physical examination should be carefully performed to determine the sphincter competency and the necessary workup which includes direct X-rays or abdominopelvic series of computed tomography in the suspicion of perforation. Initial treatment of choice in patients without signs of perforation are manual extraction attempts trans-anally. This manoeuvre is successful in the majority of cases^{7,11}.

It can be performed under pudendal nerve block and spinal anaesthesia or intravenous sedation as needed to help the patient relax, decrease the sphincter spasm and improve exposure. If the foreign body is located high in the rectum or even in the colon, endoscopic approach may be helpful in cases and a long Kocher clamp or ringed forceps can be used for extraction. If trans-anal and endoscopic approaches fail to extract the foreign bodies or there are signs of perforation, the patient should be taken for surgery. Laparotomy is required in the case of gross faecal contamination. If the objects are inadequate, a colostomy can be performed. Primary repairs can be done for lacerations of the colon which involve less than one third to half the circumference and which are fresh and without any evidence of gross peritoneal contamination.

If there is delayed presentation, gross faecal contamination, signs of abdominal sepsis or hemodynamic instability, diversion can be performed. Post extraction rectal injury should be evaluated immediately and thoroughly and the patients must be followed up in the hospital for at least 24 hours. Long term complications are rectal inflammation, perforation and resultant peritonitis, perirectal abscess and fistulae. Surgical repair should be delayed, if there is evidence of sphincter injury^{6,7}.

IV. Conclusion

Rectal foreign bodies due to auto-erotic acts may cause life threatening rectal injuries including lacerations, bleeding, perforation and obstruction. Sequential steps are essential for the diagnosis, management, and post extraction evaluation of a patient with a rectal foreign body.

References

- [1]. G.M.Gould and W.Pyle, *Anomalies and curiosities of medicine*, WB Saunders, Philadelphia, Pa, USA, 1901.
- [2]. J.S.Haft and H.B.Benjamin, "foreign bodies in the rectum : some psychosexual aspects", *medical aspects of human sexuality*, Vol.7, no.8, PP.74-95, 1973.
- [3]. G.W.G.French, D.J.Sherlock, and R.T.J.Holl Allen, "problems with rectal foreign bodies", *British journal of surgery*, Vol.72, no.3, PP.243-244, 1985.
- [4]. M.Witz, B.Shpitz, and Zager, "anal erotic instrumentation, a surgical problem", *diseases of the colon and rectum*, Vol.27, no.5, PP.331-332, 1984.
- [5]. D.B.Busch and J.R.Starling, "rectal foreign bodies : case reports and a comprehensive review of the world's literature", *surgery*, Vol.100, no.3, PP.512-519, 1986.
- [6]. J.E.Goldberg and S.R.Steele, "rectal foreign bodies", *surgical clinics of North America*, Vol.90, PP.173-184, 2010.
- [7]. J.P.Lake, R.Essani, P.Petrone, A.M.Kaiser, J.Asensio, and R.W.Beart, " management of retained colorectal foreign bodies : predictors of operative intervention", *diseases of the colon and rectum*, Vol.47, no.10, PP.1694-1698, 2004.
- [8]. M.D.Hellinger, "anal trauma and foreign bodies", *surgical clinics of North America*, Vol.82, no.6, PP.1253-1260, 2002.



Fig 1



Fig 2

Dr R Vijai. "An Interesting Case of ANO-Rectal Foreign Body." IOSR Journal of Dental and Medical Sciences (IOSR-JDMS), vol. 18, no. 3, 2019, pp 46-48.