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Different and Strange Foreign Bodies In The Rectum: Case Series Presentations

Rektumda Değişik ve Tuhaf Yabancı Cisimler: Olgu Serisi Sunumu

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Özet

Rektumdaki yabancı cisimler son yıllarda çok sık görülmektedir. Komplikasyonlarından dolayı, büyük cerrahi vakalar olarak değerlendirilmektedir. Rektumda, bulunan yabancı cisimler ya ağızdan yutulan cisimlerin rektumda takılması şeklinde veya anal kanal yoluyla rektuma sokulan cismin çıkarılamaması nedeni ile bulunmaktadır. Ağız yoluyla yutulan yabancı cisimler rektumda nadiren kalır veya ileoçekal valvdan geçtikten sonra perforsayona neden oldular. Ancak, anüsten itilen yabancı cisimler daha fazla rektal yaralanmalara neden olmaktadır. Bu amaçla, herhangi bir rektum yaralanmasına neden olmadan derhal çıkarılmaları gerekir. Bu yazıda, hızlı tanı koyduğumuz rektumda yabancı cisim hastalarının herhangi bir cerrahi girişim olmaksızın çıkarılmaları sunulmuştur.

Anahtar kelimeler: *Rektum*, *Yabancı cisim*, *Perforasyon*

Abstract

Foreign bodies in the rectum are seen very often in recent years. Because of their complications, they are one of the major surgical cases. Foreign bodies may enter the rectum in two ways – by ingesting or by being forced through the anus. Foreign bodies can be found stuck in the rectum when ingested or pushed into the rectum by the anal canal route. Ingested foreign bodies are rarely hung on in the rectum or cause injury after they pass through the ileocecal valve. But the foreign bodies which are pushed through the anus usually cause rectal injuries. For this purpose they have to be immediately taken out without causing any rectal injuries. In this article we presented patients with different foreign bodies in the rectum that had been diagnosed fast and had taken out without any surgical interventions.

Keywords: *Rectum*, *Foreign body*, *Perforation*

Introduction

Rectal foreign bodies (RFBs) are seen in an increasing rate for the last decade. They important emergency surgical cases because of their possible complications [1-3]. RFBs may enter the rectum in two ways: those inserted per annum and more rarely ingested by the mouth [3]. The oral way is mostly encountered in those with poor intellect, mentally retarded, and senile or debilitated persons, also in drug trafficking. On the other hand, RFBs inserted in the rectum per anally are noted most commonly in middle-aged men in context of autoerotic instrumentation [2,4,5].

It is very rare for RFBs ingested by the mouth get stuck in the rectum after passing iliocecal valve and cause an injury in the colon. Eighty percent to 90% of them are removed anally. But the possibility of RFBs inserted per annum getting stuck in the rectum and causing an injury is higher. Because of that; after evaluation, they have to be taken out in a controlled way and rapidly without causing any injuries in the colon [6,7].

In this case series, removal of a fast-detected RFBs inserted per annum without surgical intervention are described.

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Case Report

Case 1

A 49-year-old male was admitted to the emergency department with a complaint of abdominal pain. He gave a history of medication apparatus he used anally for hemorrhoid was held up in the anus and he was unable to take it out on his own. In examination; tough, mobile, smooth-surfaced mass, reaching up to umbilical level was palpated. Presence of a rough foreign body was noticed in 7-8 cm distance to the anal verge in digital rectal examination. Plain abdominal X-Ray revealed presence of a cylinder-shaped, considerably a long foreign body in the rectosigmoid area (Figure 1A).

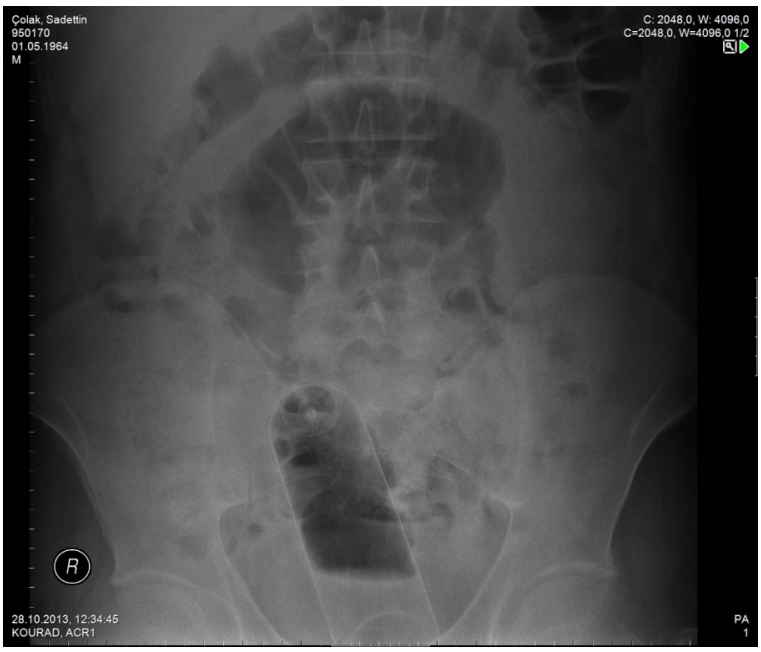

Figure 1A
Plain abdominal X-Ray revealing presence of a cylinder-shaped, considerably long foreign body in the rectosigmoid area

To verify the diagnosis, patient was taken into emergency colonoscopy and presence of body was verified. The foreign body was taken out of the anus with slow and synchronic movements by noticing mobility of foreign body and by pushing from abdomen with one hand and holding the mass via over clamp with another hand through the anus. Peroperative flouroscopic images did not reveal any additional bodies. Unlike the history the patient has given, the foreign body came out to be a hair spray bottle (Figure 1B).

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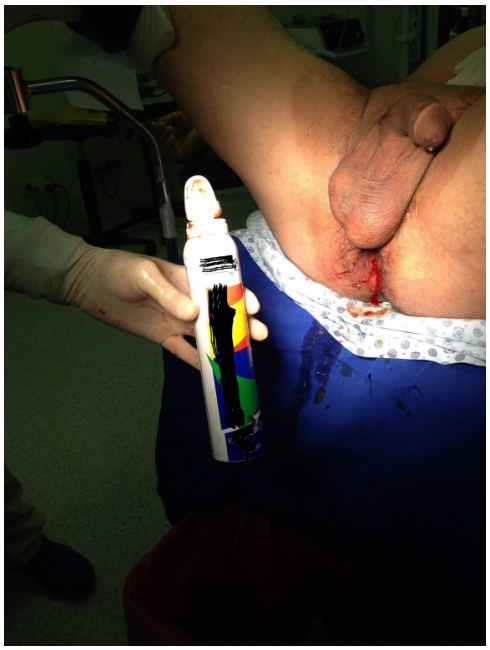

Figure 1B
The hair spray box that had been taken out of through the anus

The procedure terminated in no need for any surgical intervention. There was no complications during postoperative period. Patient was discharged after observation with standing direct abdominal x-ray daily.

Case 2

A 66-year-old male patient presented with complaints of being assaulted, having bruises and bleeding in the rectum. In the plain abdominal X-ray, a foreign body was observed in rectosigmoid area in the form of tea cup (Figure 2A).

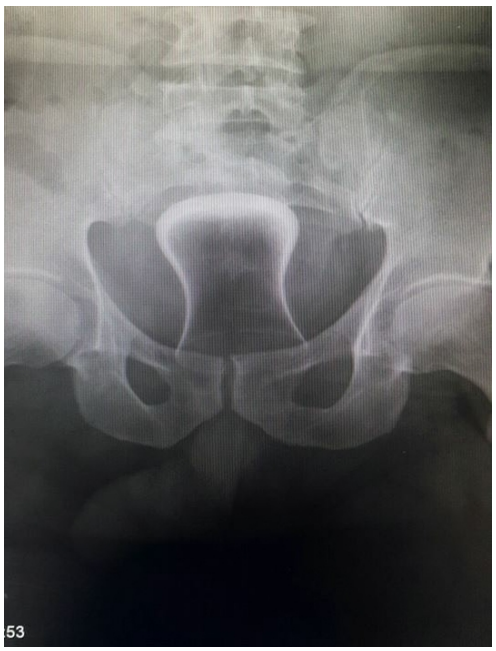

Figure 2A
Plain abdominal X-Ray revealing presence of a tea cup shaped object in the rectosigmoid area

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Under general anesthesia, the tea cup shaped object was removed from the anus bimanually under lithotomy position (Figure 2B).

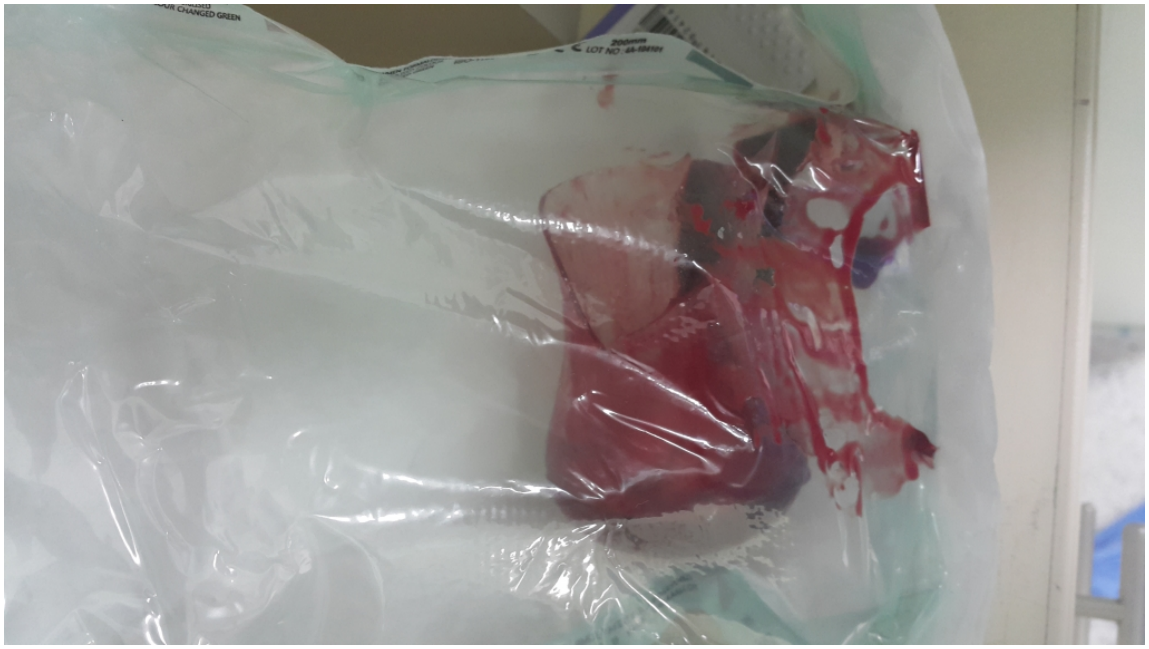

Figure 2B
The partly broken tea cup that had been taken out of through the anus

After the procedure, rectosigmoidoscopy was performed and no laceraton or perforation of rectal mucosa was detected. The abdominal x-ray was taken daily with the patient at the upright position. Patient was discharged without any complications.

Case 3

A 58-year-old male patient attended to emergency clinic with the complaint of deodorant lid in his anus. He told that he used this foreign body in order to cease the pain in his anus but he could not able to take out of it and it stuck in his anus. In the abdominal plain X-ray a cylindrical foreign body was observed in the rectosigmoid area (Figure 3A).

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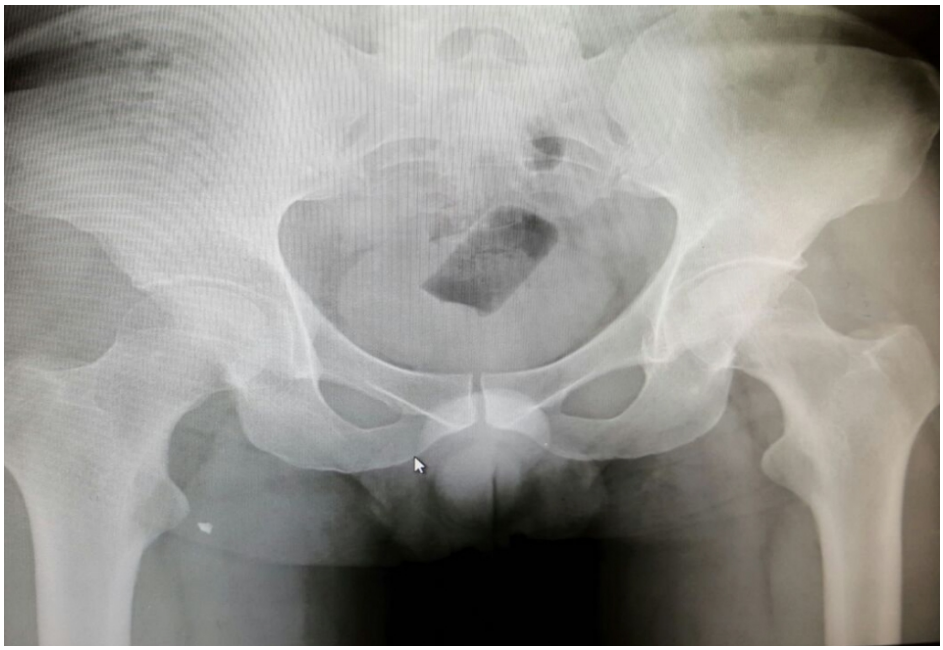

Figure 3A
Plain abdominal X-Ray revealing presence of a cylinder-shaped body in the rectosigmoid area

The deodorant cover, which was handled in the rectum, was detonated slowly and taken out of the rectum under analgesia and muscle relaxants (Figure 3B). The abdominal x-ray was taken daily with the patient standing upright. Patient was discharged without any complications.

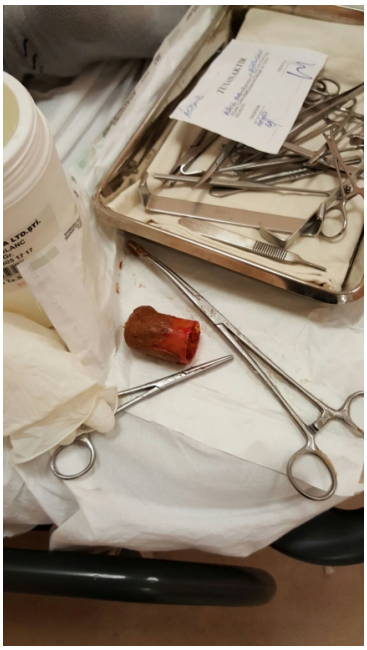

Figure 3B
The deodorant cover that had been taken out of through the anus

A 49-year-old male was admitted to the emergency department with a complaint of abdominal pain. He gave a history of medication apparatus he used anally for hemorrhoid was held up in the anus and he was unable to take it out on his own. In examination; tough, mobile, smooth-surfaced mass, reaching up to umbilical level was palpated. Presence of a rough foreign body was noticed in 7-8 cm distance to the anal verge in digital rectal

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examination. Plain abdominal X-Ray revealed presence of a cylinder-shaped, considerably a long foreign body in the rectosigmoid area (Figure 1A).

Case Discussion

Anorectal foreign bodies can either be ingested orally or inserted anally. The vast majority are inserted for autoerotic purposes, and the majority of these patients are middleaged homosexual men. Foreign bodies that are inserted into the rectum and get stuck there. These objects include bottles, glasses, cans, jars, umbrellas, vegetables, and stones in different sizes and shapes. More rarely, some drugs used to treat itching, constipation, hemorrhoids, or rectal prolapse can be inserted [2].

The most conspicious complaints patients may have are discomfort and pain in the rectum and lower abdomen. In some cases, there may be bleeding and perirectal suppuration [7].

Detailed history, full physical examination, careful rectoscopy and two-directed X-rays including abdomen and pelvis are important in diagnosis. Patients should be administered broad spectrum antibiotics and tetanus prophylaxis. And cases should be observed for genito-urinary trauma [8].

For the cases with foreign body under the rectosigmoid area, who apply without delay and have no perforation diagnosis; procedure of removal through anal way in either Sims and lithotomy position after slight sedation must be tried as first foreign body removal procedure in emergency room for palpable foreign bodies in ampulla region noticed in rectal examination. For the patients who are unable to tollerate this procedure, spinal or general anesthesia must be performed [3].

Foreign bodies cause firstly lacerations of mucosa in the rectum. These lacerations may bleed. Whether the foreign body is taken out in transanal way in early periods, lacerations of mucosa usually require treatment.

The use of enemas and stimulants to propel the object distally is not recommended, as these may cause further damage to the rectal wall. During the removal procedure if enough sphincter relaxation and dilatation cannot be supplied under appropriate anesthesia, closed lateral internal sphincterotomy could be tried [7,9]. Patient statement is important for diagnosis. Even patients do not give the correct information about how it happened, they usually give correct information about the foreign body. In our cases, how it happened part was not said correctly in the first statement.

Rectal examination may help determine structure and position of foreign body. In female patients, especially two-handed examination and manipulation are essential. Blood noticed during examination is a sign of mucosal damage. Rectoscopy, sigmoidoscopy, conventional radiographies and X-rays are taken with water-soluble contrast are highly used for diagnosis of upper rectum and sigmoid colon [8]. In our cases, foreign body was determined by palpation in digital rectal examination and standing abdominal X-ray. In addition, perforations can be shown by X-rays taken with water-soluble contrast.Transanal removal procedures must be performed as gently as possible because there may be breakings leading to injuries during this procedure [8]. It is stated that colonoscopy, Foley catheter, vacuum extractor and endothracheal tube can be utilized for transanal removal of RFBs [10]. Damage in rectum must be evaluated by rectosigmoidoscopy right after removal [7].

It is recommended that patients must be observed for at least 24 hours for development of postoperative complications. If the RFB could not be removed transanally, practitioner should perform laparotomy and primarily push the RFB into anus by intraabdominal extraluminal way and try to remove it transanally [6].

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Perforations may occur depending on RFBs. In the cases with perforation on peritoneal reflection, freeair may be noticed in direct abdominal X-rays. Perforations may be determined by follow-up rectosigmoidoscopy or X-rays taken with water-soluble contrasts in postoperative period.

In the cases with perforation; beside broad-spectrum antibiotics, if patient applies without delay, there is no peritoneal contamination and if the perforation is clear-cut and small, primary reperation may be applied. Because of fecal contamination many cases have the perforation area be repaired and then proximal loop colostomy or end sigmoid colostomy and Hartmann procedure must be performed [8].

For perforations under peritoneal reflection revealing as cellulite, Fournier gangrene or abscess; some practitioners recommend that interventions should be decided depending on patient; add to this some perform end colostomy and fecal divertion as mucous fistula and presacral drainage if necessary. If there is no clear inflammation, anal sphincter injuries should be repaired primarily.

Orally ingested drug packets can be ruptured itself depending on the duration of staying in gastro instestinal system. İn the removal procedure of these highly fragil packets, pratitioner should not perform endoscopic interventions in order to avoid deadly toxicity that rupture may cause. Surgical interventions should be performed on the cases which have immobile packets and possibility of rupture [11].

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Information Presantation

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