

## Case Report

### Rectal Foreign Body in a 30 Year Old Male- A Case Report.

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#### Abstract:

*Though anorectal foreign body cases are rare, they have become increasingly frequent in recent years. Although entrapped foreign bodies are most often related to sexual behavior, they can also result from ingestion or sexual assault. The diagnosis may be made by rectal examination and metallic objects can be confirmed by plain abdominal radiographs. Transanal removal is only possible for very low-lying objects, while patients with high-lying foreign bodies usually require an operative intervention. An early decision of laparotomy should only be made after subjecting the patient to suitable investigations to determine exact location of the object, in order to avoid any inadvertent damage to the adjoining vasculature as well as anal incontinence. We report the case of a young male who presented at surgery department of Shaheed Suhrawardy medical college hospital with severe rectal pain due to insertion of an apple into rectum by some eunuchs. It was successfully removed transanally under spinal anesthesia. Post operative period was uneventful and referred for psychiatric consultation.*

#### Key Words:

Rectum, foreign body, sodomy, eunuchIntroduction:

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Rectal foreign bodies (RFB) are large foreign items found in the rectum that can be assumed to have been inserted through the anus, rather than reaching the rectum via the mouth and gastrointestinal tract. It usually occur for purposes of sexual gratification, voluntarily, assault or accidentally. This is often because of the delayed presentation, wide variety of objects that cause the damage, and the wide spectrum of injury patterns that range from minimal extra peritoneal mucosal injury to free intraperitoneal perforation, sepsis, and even death. Management of patients with rectal foreign bodies can be challenging. A systematic approach is proposed to avoid pitfalls. A problem commonly encountered in patients with RFB is the delay in presentation<sup>1,2</sup>. While patients may be reluctant to disclose the cause of their presentation, diagnosis can be made in the majority of cases with accurate history and confirmed with plain

radiographs. It is important to rule out signs and symptoms of peritonitis. An attempt at manual retrieval of the foreign body is always warranted as a first step, with or without light sedation. If this is unsuccessful, or there is evidence of significant bowel injury or even perforation, surgical intervention is warranted. In this report we describe a case of a 30 year male that has history of insertion of an apple in rectum by some eunuch.

#### Case Report:

A 30 year old male presented with severe rectal pain for 24 hour, inability to pass stool for same duration. He had history of sexual exposure with eunuch several times for last 6 month. Last day during his habitual sodomy with a eunuch another eunuch insert an apple into his rectum. He had no history of abdominal pain, distention or vomiting. On examination patient was anxious looking, abdomen was soft, non-distended and non-tender to palpation, without signs of peritonitis. Bowel sounds were normal. Digital rectal examination reveals patulous anus with loss of sphincter tone and a foreign body having smooth surface was just felt by finger tip about 10 cm from anal verge. It was impossible to retrieve with simple maneuvering, including simultaneous application of suprapubic pressure. Proctoscopy was not attempted, as the anal canal was well dilated and distal rectal mucosa were easily seen and examined with a rectal speculum. Mild mucosal hyperemia was noted, but there was no evidence of tears or ischemic compromise to the rectal

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mucosa. As the patient was very uncomfortable with our maneuvers, despite maximal intravenous analgesia, we elected to proceed with an examination under anesthesia and possibly surgical intervention. Other systemic examination revealed no abnormality.

After fluid resuscitation and preoperative intravenous antibiotics, the patient was brought to the operating room, where he was anesthetized by SAB and placed in the lithotomy position. It was not visualized because of more distal placement but it was felt by finger tip. An attempt to remove the foreign body manually with lubrication was unsuccessful due to large size. Thereafter we made an attempt to crush the apple into piecemeal by sponge holding forceps and finally we retrieve the whole apple. After removal rectum was checked and no tear or mucosal injury was found. Post operatively seize bath was advised with antiseptic lukewarm water.

As patient had multiple sexual exposures, we advised some investigation to rule out STD. HBsAg, AntiHCV, VDRL were nonreactive. TPHA and Anti HIV (1+2) were negative. Patient was counseled to give up the bad habit and discharged on 2nd post operative day.



**Fig.-1:** Pieces of apple after extraction.

### Discussion:

Rectal foreign bodies, even though rather infrequent, are no longer considered clinical oddities in urgent care facilities and emergency departments, and it appears that their incidence is increasing, specifically in urban populations.<sup>1,3</sup> Although the medical literature is replete with numerous case reports and case series of RFB in

patients of all ages, genders and ethnicities,<sup>1-10</sup> the majority are male in their 3rd and 4th decades.<sup>1-3</sup> Foreign bodies can be inserted in the rectum for sexual gratification or non-sexual purposes. Numerous types of objects have been described in the literature (ranging from fruits and vegetables, cosmetic containers,<sup>4,5</sup> cans or bottles, batteries, light bulbs and childrens'<sup>9</sup> or sex toys<sup>5</sup>, and all of them should be regarded as potentially hazardous of causing significant injury.

More often than not, patients who present to the emergency department with RFB have attempted to remove the object unsuccessfully prior to seeking medical care.<sup>3</sup> Pelvic or even abdominal pain, if perforation has occurred above the peritoneal reflection, bleeding per rectum, rectal mucous drainage, even incontinence or bowel obstruction can be the presenting symptoms.

Physical examination is centered around ruling out peritonitis. A rectal examination should be performed, to assess the distance of the RFB from the anal verge and to determine sphincter competency. Routine laboratories are recommended to assess the extent of physiologic derangement from the presence of the RFB. An abdominal series would define the nature, size and shape of the foreign body, its location, and rule out subdiaphragmatic free air.

Once work up is complete, rigid proctoscopy should be undertaken if possible – especially for foreign bodies high up in the rectum, when digital examination is insufficient – to assess the degree of rectal mucosal injury, visibility of the foreign body and its distance from the anal verge. Care should be taken to prevent further pushing the rectal body higher up in the rectosigmoid.

After complete assessment, an attempt at manual extraction transanally should be made. This is successful in the majority of cases. Pudendal nerve block<sup>1</sup>, spinal anesthetic<sup>1,2,8,10</sup>, and/or intravenous conscious sedation<sup>4,5</sup> can be utilized as needed to help the patient relax, decrease anal sphincter spasm. The anal canal should be dilated gently, and if the foreign body is palpable, it may be grasped and extracted manually, following the rectosigmoid axis. If the foreign body is higher up, the anal canal should be gently dilated with a speculum and the rectum insufflated. A long Kocher clamp or ringed forceps can be used for extraction. Having the patient perform a Valsalva maneuver during the attempt may facilitate the process. In case of fragile items, such as light bulbs and bottles, attention should be paid at excessive manipulation so they do not break inside the rectum creating further injury.

Endoscopy is mainly helpful in cases where the foreign body is located high in the rectum or even in colon. Endoscopic snares and gentle insufflation in the bowel to help loosen the seal around the RFB have both been described.

If transanal and endoscopic approaches fail to retrieve the foreign object or there are peritoneal signs the patient needs to be taken for surgery. Laparotomy is the last option. If the RFB is successfully extracted, the distal colon should be assessed again for injuries using proctoscopy. Those with lacerations of the colon that involve less than one third to half the circumference and are fresh and not accompanied with gross peritoneal contamination can be repaired primarily. Diversion should also be considered in patients with delayed presentation, significant fecal contamination, signs of sepsis and hemodynamic instability.

In this case we were able to retrieve the apple from rectum by sponge holding forceps.

Endoscopic surveillance of the colonic mucosa immediately after RFB removal sometimes necessary to rule out inadvertent extraction-related injury and perforation.<sup>1,3</sup> Even if transanal extraction was performed without difficulty, close observation for many hours with serial abdominal examinations is recommended.<sup>1</sup>,

#### **Conclusion:**

The case we have presented here is not only a clinical matter but also a social issue. The patient had a sexual perversion and was very much habituated with sodomy with eunuch. Lastly he was a victim of assault by those

eunuchs. Different reports show foreign body of metal or glass but apple is a rare rectal foreign body which we found in this case. After successful removal of foreign body proper counseling was made to give up sodomy and was referred to psychiatrist for further management.

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