Scholars Journal of Medical Case Reports
Abbreviated Key Title: Sch J Med Case Rep
ISSN 2347-9507 (Print) | ISSN 2347-6559 (Online)
Journal homepage: https://saspublishers.com

OPEN ACCESS

Visceral & Digestive Surgery

Intrarectal Foreign Body: Case Report

Serges Maniradukunda[1,2*], Habib Cherif[1,2], Chaimae Moradi[1,2], Imane Toughrai[1,2], Karim Ibn Majdoub[1,2]

[1]Department of Visceral and Digestive Surgery, CHU HASSAN II, Fès, Morocco
[2]Faculty of Medicine and Pharmacy, Sidi Mohammed Ben Abdellah University, Fez

DOI: https://doi.org/10.36347/sjmcr.2025.v13i05.001 | **Received:** 06.02.2025 | **Accepted:** 11.03.2025 | **Published:** 02.05.2025

***Corresponding author:** Serges Maniradukunda
Department of Visceral and Digestive Surgery, CHU HASSAN II, Fès, Morocco

Abstract **Case Report**

Anorectal foreign bodies are usually objects that have been inserted into the rectum through the anus, but they can also be swallowed objects. Sudden, transfixing pain during defecation should raise suspicion of the presence of a foreign body, usually blocked at or just above the anorectal junction. The presence of red blood indicates that a tear or perforation may have occurred. Other manifestations depend on the size and shape of the foreign body, its age in situ and the presence of infection or perforation. Diagnosis is usually based on digital examination, and sometimes an unprepared abdominal X-ray. Treatment is often manual extraction under local anaesthetic or sedation, or by sigmoidoscope. Surgery is reserved for cases where manual or endoscopic extraction of the foreign body has failed. We report a case of a patient who had an incarceration of a huge object voluntarily introduced anally for therapeutic purposes.

Keywords: Foreign Body, Rectum, Anal Passage, Self-Treatment, Constipation.

Copyright © 2025 The Author(s): This is an open-access article distributed under the terms of the Creative Commons Attribution **4.0 International License (CC BY-NC 4.0)** which permits unrestricted use, distribution, and reproduction in any medium for non-commercial use provided the original author and source are credited.

INTRODUCTION

The introduction of foreign bodies through the anus is a well-described phenomenon, but one that is still considered curious and taboo in developing countries. The introduction of the object is rarely accidental. It is most often voluntary, due to behavioral problems, to conceal the object (drugs, etc.) or to relieve constipation. Aggression and anal eroticism are two other causes. These foreign bodies are highly diverse and unusual in nature. Insertion of a foreign body is found on questioning. However, some patients do not report it immediately. A rare but possible situation is a foreign body swallowed (fish bone, chicken bone, etc.) and impacted in the rectum. If the object is radio-opaque, an unprepared abdominal X-ray can confirm the diagnosis, and is normal for a radiolucent foreign body.

OBSERVATION

A 28-year-old patient with no prior history of any kind, presented to the emergency department with abdominal pain with sub-occlusion in connection with a foreign body that had been incarcerated intra-rectally since its introduction three days previously to treat constipation. Clinical examination revealed a patient in apparently good general condition, hemodynamically and respiratorily stable, and apyretic. Abdominal examination revealed a flat, unscarred abdomen, breathing normally. The hypogastric mass could be palpated, generating pain on palpation. Rectal examination combined with abdominal palpation revealed the distal tip of the object at the tip of the finger. There was no trace of blood when the finger was withdrawn.

An unprepared abdominal X-ray showed the foreign body projecting into the pelvis (Fig1). Extraction by vaginal approach using heart-shaped forceps was performed under sedation, in the operating room, in the perineal pruning position. The core measured almost 15 cm (Fig2, Fig3). The patient was kept under observation after extraction. Progress was good, and effective gas and stool transit was resumed the day after extraction. A clinical examination the following day was unremarkable. The patient was declared discharged on D+1.

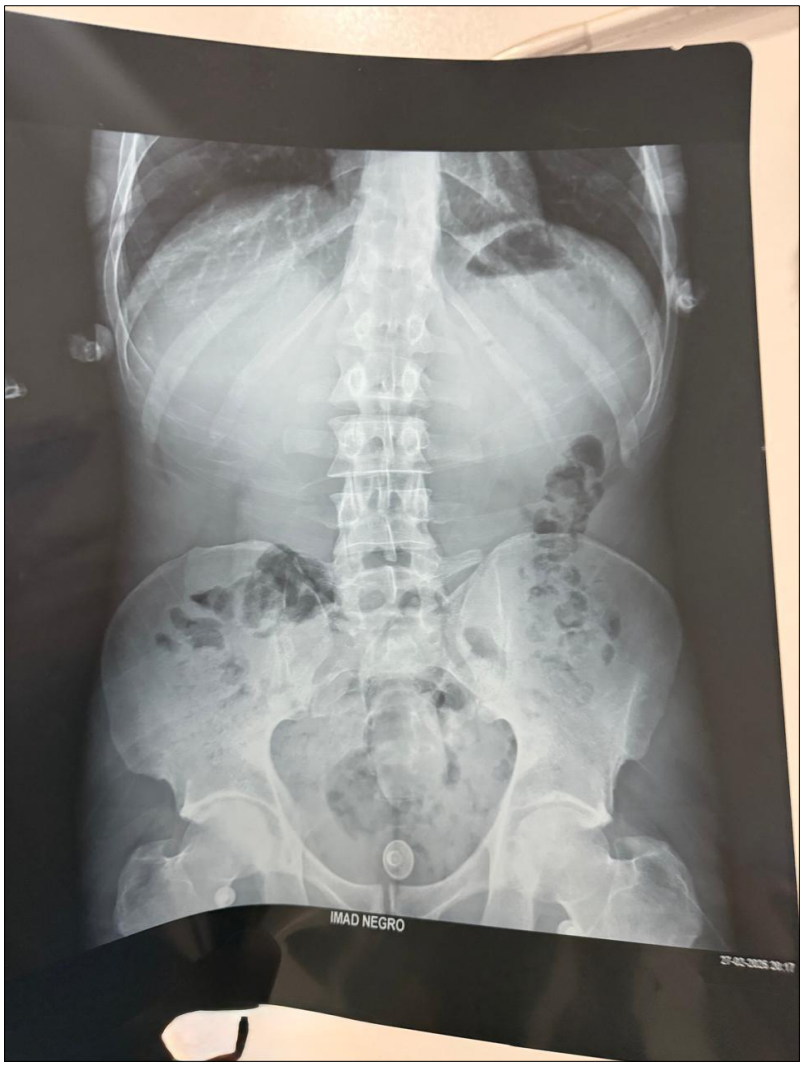

Fig. 1: Unprepared abdominal X-ray showing a cylindrical object projecting into the pelvis with no radiological signs of occlusion or pneumoperitoneum.

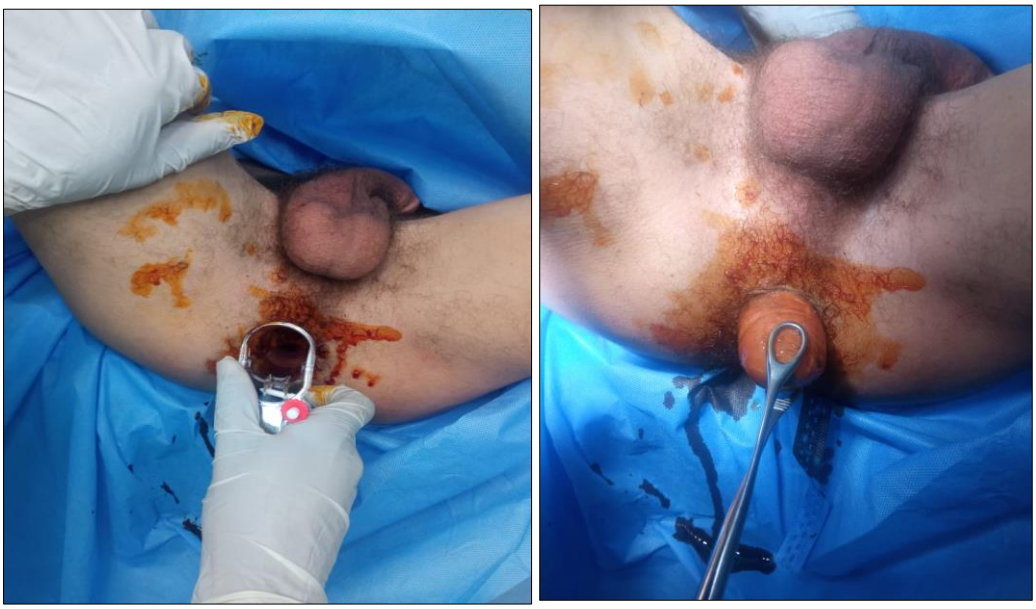

Fig. 2: Extraction of foreign body with forceps under sedation

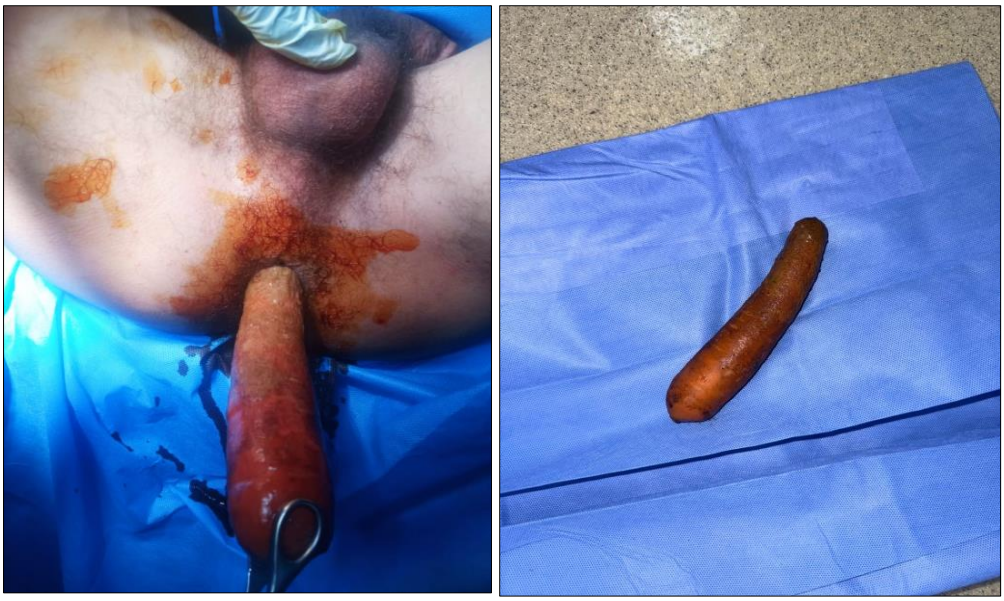

Fig. 3: Extracted foreign body, carrot

DISCUSSION

If a foreign body is inserted intrarectally, it is imperative not to make the patient feel guilty. They must be psychologically relieved and treated with the same respect shown to other patients. This is not only ethical, it also facilitates management. A digital rectal examination (DRE), performed under sedation, verifies anorectal integrity and can locate the foreign body [1].

The first description of the management of an intra-rectal foreign body dates back to the 16th century [2]. A distinction is made between the incarceration of foreign bodies ingested buccally and those introduced rectally for various reasons.

The most frequent cause of foreign body insertion is related to sexual practices, mostly solitary. Other etiologies are self-therapeutic on the occasion of constipation, hemorrhoids or anal pruritus, traumatic origin, assaults, and psychiatric or accidental origin [3]. Our patient reports the introduction of the foreign body for self-therapeutic purposes, although the hypothesis of solitary sexual practice cannot be ruled out. Other causes mentioned, such as a “bet” between friends or the case of body-packers (“mules”) transporting drugs.

The presence of intra-rectal foreign bodies is not common in developing countries [4], and is sometimes considered taboo. This explains the delay in consulting patients, which can expose them to serious complications. The onset of symptoms associated with the introduction of a CE motivates patients to consult the emergency department, often several hours or days after insertion of the foreign body, with an average delay of 1.9 days [2]. Our patient presented three days later.

The main reasons for consultation were rectal discharge and acute or persistent abdominal pain associated with an occlusive or sub-occlusive syndrome. Tenesmus or anorectal discomfort are often cited [5].

A digital rectal examination combined with abdominal palpation can be used to estimate the position of the foreign body [6]. If the object is radio-opaque, the diagnosis is confirmed by a unprepared abdominal X-ray, which will show its shape, size and position. Unprepared abdominal X-ray may also reveal pneumoperitoneum, a sign of digestive perforation requiring emergency laparotomy. Foreign bodies can cause intestinal or vascular erosions, abscesses, obstruction and hemorrhage [7].

If the diagnosis is made before the complication stage, extraction would be essential, except that this also poses a problem. It should be performed vaginally whenever possible. Locoregional or even general anaesthesia in the operating theatre is required to relax the anal sphincters [8]. Successful extraction by the vaginal route has been reported, but mainly in small ECs [8]. In our patient, despite the considerable size of the object, vaginal extraction was successful. Factors such as the size, shape and migration of foreign bodies can make it difficult to find and extract them vaginally. In the event of failure, laparotomy may be necessary [9, 10], to push the object back into the rectal ampulla without opening the colon. However, in the case of large foreign bodies, surgical removal of the EC by colonic opening may be necessary [11]. The placement of an upstream stoma depends on perineal trauma, the chronicity of the situation, and the condition of the colorectal wall as assessed intraoperatively [12]. Finally, psychological support is necessary in all cases, including psychiatric follow-up.

CONCLUSION

Colorectal foreign bodies introduced via the anal route are infrequent occurrences in our practice, but practitioners may be confronted with them. Their management requires ingenuity on the part of the practitioner, who must conduct a meticulous interrogation with strict respect for the patient's privacy, a rigorous clinical examination and rapid extraction to avoid serious complications, thus limiting recourse to surgery, which remains the last option in the event of manual and endoscopic extraction failure. Psychological support, including psychiatric follow-up, is necessary in all cases.

Role of Funding Source: No funding was received for the preparation of this study.

Declaration of Competing Interests: The authors declare that they have no conflicts of interest.

REFERENCES

1. Kouraklis, G., Misiakos, E., Dovas, N., Karatzas, G., & Gogas, J. (1997). Management of foreign bodies of the rectum: report of 21 cases. *Journal of the Royal College of Surgeons of Edinburgh*, *42*(4), 246-247.
2. Lake, J. P., Essani, R., Petrone, P., Kaiser, A. M., Asensio, J., & Beart Jr, R. W. (2004). Management of retained colorectal foreign bodies: predictors of operative intervention. *Diseases of the Colon & Rectum*, *47*(10), 1694-1698.
3. Kurer, M. A., Davery, C., Khan, S., & Chintapatla, S. (2009). Colorectal foreign bodies: a systematic review. *Colorectal Diseases*, *12*(9), 851-861. doi: 10.1111/j.1463-1318.2009.02109.
4. Rakatovao, M., Razafimahatratra, R., Rakotomena, S. D., & Rakoto-Ratsimba, H. N. (2008). Aspects de la prise en charge des corps étrangers intra-rectaux dans les pays en développement. *Revue tropicale de chirurgie*, *2*, 16-17.
5. Kann, B. R., & Hicks, T. C. (2004, June). Anorectal foreign bodies: Evaluation and treatment. In *Seminars in Colon and Rectal Surgery* (Vol. 15, No. 2, pp. 119-124). WB Saunders.
6. Kouraklis, G., Misiakos, E., Dovas, N., Karatzas, G., & Gogas, J. (1997). Management of foreign bodies of the rectum: report of 21 cases. *Journal of the Royal College of Surgeons of Edinburgh*, *42*(4), 246-247.
7. Dje, K., Turquin, T. H., Kouassi, R., Attoumo, R., & Kouadio, L. (1999). Corps étranger insolite de l'espace de Retzius, à propos d'un bout de bois pelvien. *Médecine d'Afrique Noire*, *46*(3), 181-183.
8. Clarke, D. L., Buccimazza, I., Anderson, F. A., & Thomson, S. R. (2005). Colorectal foreign bodies. *Colorectal Disease*, *7*(1), 98-103.
9. Cirocco, W. C. (2000). Anesthesia facilitates the extraction of rectal foreignbodies. *Gastrointestinal endoscopy*, *52*(3), 452-453.
10. Hoitsma, H. F., Meijer, S., & De Jong, D. (1984). The transsphincteric approach for removal of a huge foreign body from the rectum. *The Netherlands Journal of Surgery*, *36*(3), 83-84.
11. Chris Kantarian, J., Riether, R. D., Sheets, J. A., Stasik, J. J., Rosen, L., & Khubchandani, I. T. (1987). Endoscopic retrieval of foreign bodies from the rectum. *Diseases of the colon & rectum*, *30*, 902-904.
12. Ousadden, A., IbnMajdoub, K., El Bouhaddouti, H., Lamrani, J., Mazaz, K., & AitTaleb, K. (2009). Voluntarily introduced colorectal foreign bodies: A propos de quatre cas. AMÉTHER, 1(1), 22-25.