SAS Journal of Surgery
Abbreviated Key Title: SAS J Surg
ISSN 2454-5104
Journal homepage: https://www.saspublishers.com

OPEN ACCESS

General Surgery

An Interesting Surgical Case of Unyielding Intruder of Rectum

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DOI: https://doi.org/10.36347/sasjs.2026.v12i01.010 | **Received:** 04.11.2025 | **Accepted:** 12.01.2026 | **Published:** 14.01.2026

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Abstract **Case Report**

Background: Rectal foreign bodies represent a rare but challenging surgical emergency, often due to voluntary insertion for various reasons, leading to impaction, obstruction, and potential perforation. Management ranges from transanal retrieval to laparotomy for proximal objects. ***Case Presentation:*** A middle-aged male presented with lower abdominal pain and obstipation for 2 days. Digital rectal examination revealed a collapsed rectum without palpable mass. Imaging confirmed a radiolucent cylindrical foreign body (? plastic) in the lower rectum, with colonoscopy showing mucosal erosions, ulcers, and the object at the rectosigmoid junction. Exploratory laparotomy with sigmoid enterotomy facilitated removal of a 20 cm long broom stick handle, followed by sigmoid loop colostomy. Postoperative recovery was uneventful, with colostomy closure after 6 months. ***Conclusion:*** High impacted rectal foreign bodies necessitate tailored surgical intervention. Psychiatric evaluation is essential to prevent recurrence.

Keywords: Rectal foreign body, rectosigmoid impaction, laparotomy, sigmoid enterotomy, colorectal emergency, abnormal sexual behaviour.

INTRODUCTION

Rectal foreign bodies occur due to assault, accidental trauma, concealment, or sexual stimulation, with incidence underreported owing to social stigma and embarrassment. Mean age of presentation being 53.8 ± 15.5 years (range, 1 ~ 88 years) among which (77.3%) were male and (22.7%) were female [6]. Risk factors include abnormal sexual behaviour and psychosocial disorders. Complications encompass mucosal tears, obstruction, perforation, and sphincter injury. Initial management involves anal dilatation under anaesthesia; colonoscopy; laparotomy is reserved for proximal impactions. This report details a rare case requiring surgical intervention for a large impacted object.

Impaction of foreign bodies in the rectosigmoid junction is an uncommon but important surgical emergency that poses significant diagnostic and therapeutic challenges. The rectosigmoid junction is a frequent site of impaction because of its sharp angulation, reduced luminal diameter, and relative fixation, which hinder spontaneous passage and transanal retrieval. Plastic foreign bodies are particularly difficult to manage as they are, often non-radiopaque, and resistant to grasping with conventional instruments, increasing the likelihood of failed non-operative removal attempts [1].

Patients often present late due to embarrassment or social stigma, leading to delayed diagnosis and higher risk of complications. Clinical manifestations range from vague rectal discomfort and constipation to acute abdominal pain, intestinal obstruction, perforation, peritonitis, and sepsis [2]. A thorough history, clinical examination supplemented by appropriate imaging is essential for accurate localization of the foreign body and for identifying complications such as bowel perforation or pneumoperitoneum. While plain radiographs are useful, computed tomography plays a pivotal role in evaluating non-radiopaque objects and associated injuries [3].

Most rectal foreign bodies can be managed successfully by transanal or endoscopic extraction under adequate anesthesia. However, surgical intervention becomes mandatory when these methods fail or when complications such as perforation, ischemia, or peritonitis are present [4]. Laparotomy remains the definitive approach in such complex cases, allowing safe removal and management of associated bowel injury. This case report describes a rare instance of an impacted

plastic foreign body at the rectosigmoid junction requiring laparotomy, highlighting the clinical presentation, management challenges, and the importance of timely surgical intervention.

Case Presentation

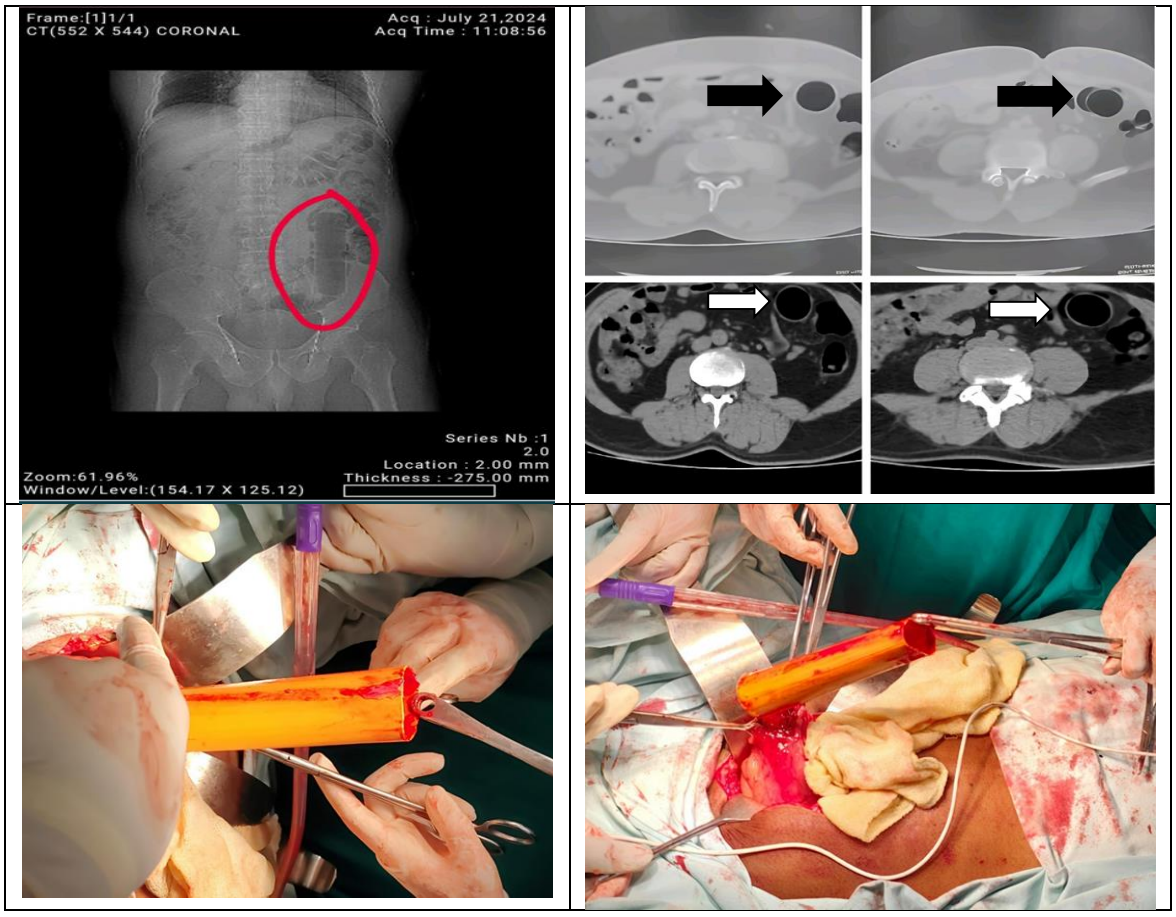
A53 years male presented with lower abdominal pain and obstipation lasting 2 days. Patient gave an inappropriate history of fall from height with accidental entry of a plastic object into rectum. On thorough history taking finally revealed self-insertion of broom stick handle through anus for pleasure. Per abdomen examination showed a soft, non-tender abdomen. Digital rectal examination (DRE) indicated a collapsed rectum with no palpable mass or object.

Clinical Findings and TimeLine

Day 0 (Presentation): Erect X-ray abdomen revealed a well-defined cylindrical radiolucent shadow. CT abdomen suggested a plastic foreign body in the lower rectum.

Day 1: Colonoscopy confirmed the foreign body in the rectum with mucosal erosions and multiple linear ulcers. Attempts to retrieve the broom stick handle were failed due to bowel edema and risk of perforation.

Operative Intervention: Exploratory laparotomy identified a ~20 cm rigid object at the rectosigmoid junction. Sigmoid enterotomy enabled complete removal of the broom stick handle, followed by sigmoid loop colostomy.



Postoperative: Uneventful recovery. Sigmoid loop colostomy closure performed after 3 months

Timeline	Event	Findings/Intervention
Presentation	Pain, obstipation	Soft abdomen, empty DRE
Imaging	X-ray, CT	Radiolucent cylindrical object, plastic
Endoscopy	Colonoscopy	Erosions, ulcers, a plastic object visualized
Surgery	Laparotomy	20 cm long broom stick handle removed via enterotomy + colostomy
Follow-up	6 months	Colostomy closure

DISCUSSION

Rectal foreign bodies challenge removal ingenuity more than insertion. A high index of suspicion is required to accurately diagnose a rectal foreign body as patients are often embarrassed about their condition and may not present in a timely fashion to be evaluated or volunteer their history. Conservative approaches suffice for distal objects, but proximal impactions like this rectosigmoid case demand laparotomy to avert perforation. Postoperative colostomy mitigated contamination risks. Psychiatric counselling addresses underlying psychosocial factors to curb recurrence, a key recommendation in literature. This case underscores vigilant imaging and multidisciplinary care in such rarities.

Patient consent: Written informed consent was obtained from the patient for publication of this case report and accompanying images.

Conflicts of interest: The authors declare no conflicts of interest.

Funding: No specific grant from any funding agency was received for this work.

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