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Surgery

Management of an Intrarectal Foreign Body in A Patient with A Psychiatric Disorder: A Case Report

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Abstract **Case Report**

Introduction: Intrarectal foreign bodies are a rare medico-surgical emergency, often associated with delayed presentation. ***Case report:*** We report the case of a 51-year-old man with an undocumented psychotic disorder treated with alprazolam, who presented to the emergency department with diffuse abdominal pain evolving for three days after the voluntary insertion of an approximately 30 cm rod into the rectum. Clinical examination was unremarkable except for a foreign body palpable on digital rectal examination. Radiologic workup (plain abdominal X-ray and CT scan) confirmed the presence of the foreign body without complications. Manual extraction was performed in the operating room under sedation, with favorable outcome. ***Discussion:*** Management depends on the nature of the object, its location, and the presence of complications. Transanal extraction remains the first-line treatment in the absence of signs of severity. ***Conclusion:*** Prompt and appropriate management can prevent complications. Psychiatric evaluation is recommended.

Keywords: Intrarectal foreign body, emergency, extraction, psychosis.

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INTRODUCTION

Intrarectal foreign bodies represent an unusual but increasing clinical situation. Their management poses a diagnostic and therapeutic challenge because of the variety of clinical presentations and the risk of complications. Causes are varied, including sexual practices, psychiatric disorders, and certain accidental situations. We report a case illustrating the management of an intrarectal foreign body in a patient with a psychiatric disorder.

CASE PRESENTATION

The patient was a 51-year-old man followed for an undocumented psychosis, treated with alprazolam, who was admitted to the emergency department for diffuse abdominal pain lasting three days. History revealed the voluntary insertion of an intrarectal foreign body, described as a rod approximately 30 cm long, which occurred three days before admission. On clinical examination the general condition was preserved. Abdominal examination was unremarkable: the abdomen was soft, non-tender, without guarding or rigidity. Digital rectal examination allowed palpation of the foreign body. Additional workup included routine laboratory tests, a plain abdominal radiograph, and an abdominopelvic CT scan, confirming the presence of the foreign body without signs of complication, notably without perforation. The patient underwent manual extraction of the foreign body in the operating room under sedation. The procedure was uneventful. The postoperative course was simple, with resolution of pain and no complications.

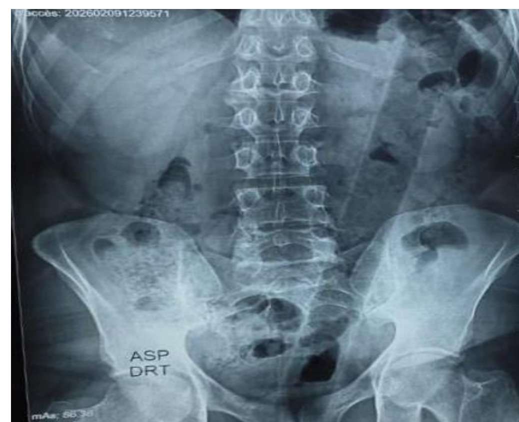

Figure 1: ASP view showing the image of the foreign body (stick)

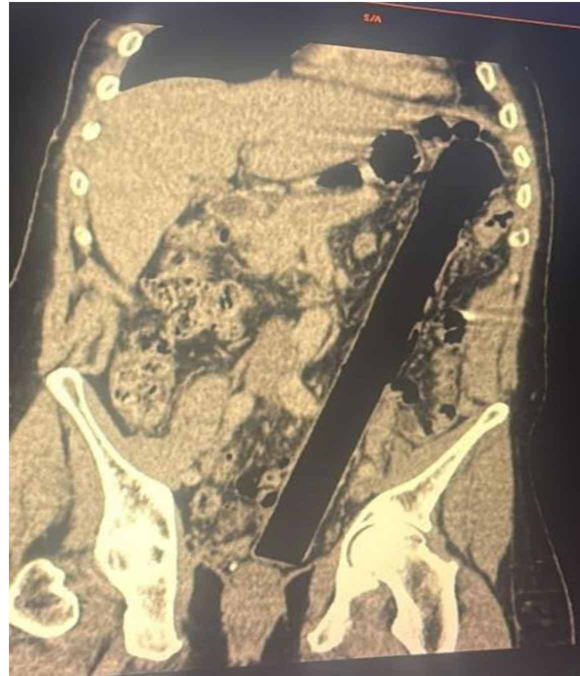

Figure 2: Emergency CT scan image showing the foreign body.

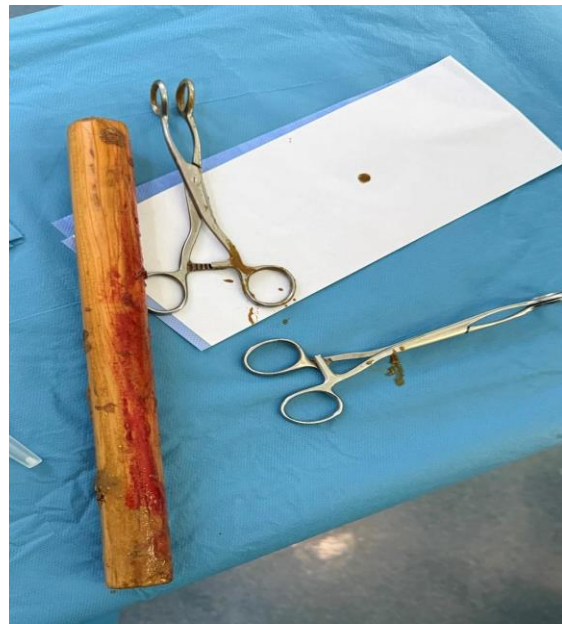

Figure 3: Foreign body after manual extraction in the operating room

DISCUSSION

Intrarectal foreign bodies represent a rare clinical entity but are probably underreported, often associated with delayed consultation due to embarrassment or psychiatric context [1,2]. In our case, the 72-hour delay between insertion and consultation fits this typical pattern.

The etiologies are mainly related to sexual practices, but psychiatric disorders, as in our patient with undocumented psychosis, are recognized risk factors [2,4]. This particular background may complicate history-taking and delay management.

Clinically, presentation is variable, ranging from isolated abdominal pain to severe cases of digestive perforation [3,5]. In our observation, the abdominal examination was normal, which is described in uncomplicated forms. Digital rectal examination remains a key assessment, often confirming the presence of the foreign body, as in our patient [1,6].

Imaging plays a central role. Plain abdominal radiography helps localize the object and guide management, while CT scanning is indicated in cases of diagnostic uncertainty or to assess for complications, particularly perforation or pneumoperitoneum [1,3]. In

our case, the absence of complications allowed consideration of non-surgical extraction.

Management depends on several factors: size, shape, nature of the object, location, and presence of complications [2,7]. Long objects (>10 cm), such as the one observed in our patient (30 cm), may pose extraction difficulties.

However, in the absence of severe signs, transanal extraction remains the first- line therapeutic option [1,2]. Use of the operating room with sedation, as in our case, allows better sphincter relaxation and increases the likelihood of success.

Surgery is reserved for failed extractions or complications [3,10]. Outcomes are generally favorable when management is early and appropriate, as observed in our patient.

Finally, comprehensive care should include psychiatric evaluation, particularly in patients with mental disorders, to prevent recurrence [2,4].

Conclusion

Intrarectal foreign bodies require prompt and appropriate management to prevent complications. Transanal extraction is the preferred first-line approach in the absence of severity signs. A multidisciplinary approach, including psychiatric evaluation, is essential to prevent recurrence.

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