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Intra-Rectal Foreign Body Revealing Ulcerative Colitis

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Abstract **Case Report**

The insertion of objects into the rectum is uncommon in countries with a socio-cultural context such as Morocco. It is characterized by the severity of complications. We report the case of a patient, who had a voluntary introduction of a corticosteroid tube intra rectally to relieve a rectal syndrome. He benefited from an endoscopic extraction and the exploration of the mucosa objectified an aspect in favor of an IBD in severe attack, confirmed later by histology.

Keywords: Foreign body, self-medication, topical corticosteroid therapy, ulcerative colitis.

INTRODUCTION

For decades, the introduction of foreign bodies into the rectum has become an increasingly frequent reason for emergency consultation. Different motives can be reasons behind these practices; however, the dominant motives are of a sexual, therapeutic, psychic nature.

PATIENT AND OBSERVATION

A 62-year-old patient with a history of non-monitored psychosis presented to the emergency room for a sub- occlusion related to a foreign body imprisoned intra-recally for 5 days previously in order to treat a rectal syndrome. The general examination of our patient on admission was unremarkable, as was the abdominal examination. The digital rectal examination carried out in the emergency department revealed a foreign body whose manual extraction is impossible. An abdominal CT scan is requested to rule out any complications, it turned out to be unremarkable apart from the presence of the foreign object. Endoscopic extraction using a dormia was done under sedation, at the operating room. It was a tube of topical corticosteroids introduced voluntarily (Figure 1). The patient reported that to relieve his rectal syndrome, he had recourse to topical corticosteroid applications and enemas by himself, and given the worsening of the symptomatology, he introduced the entire tube intra-rectal voluntarily. Endoscopic exploration of the rectal mucosa objectified an erythematous granitic mucosa, with the presence of superficial ulcerations on a geographical map with the presence of signs of gravity such as digging ulcerations and pit ulcerations (Figure 2). This endoscopic aspect evoked an inflammatory bowel disease in endoscopic thrust, hence the realization of biopsies at the level of the colorectal mucosa which returned in favor of ulcerative colitis. The patient was put on intravenous corticosteroid therapy as treatment for the ulcerative colitis. The evolution was favorable, and the patient was referred to psychiatry department for psychological support.

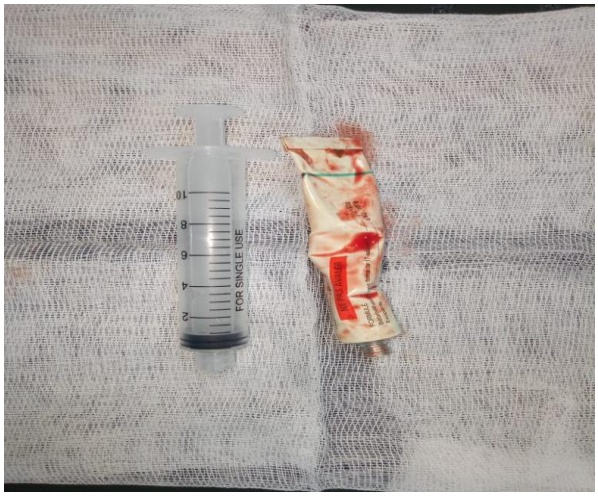

Figure 1: Foreign body after removal

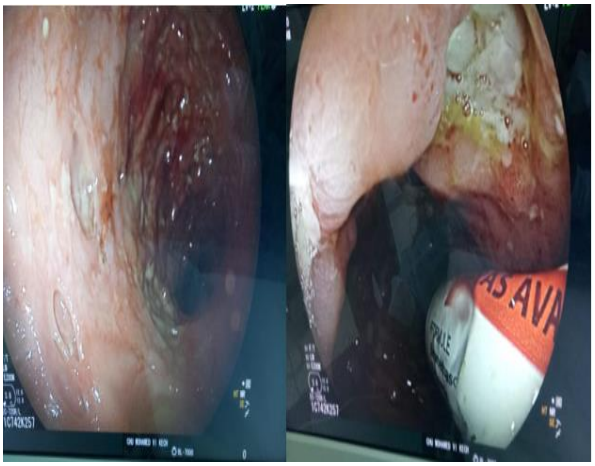

Figure 2: Erythematous rectal mucosa with presence of ulcerations in geographical map, digging and ulcerations in pits and presence of a foreign body intra rectal

DISCUSSION

Over the past few decades, publications on the management of intra-rectal foreign bodies have only increased [1]. The objectives of inserting these foreign bodies are multiple, dominated by voluntary sexual practices, less frequently for reasons of self-medication or aggression, or following psychiatric disorders [2]. Our patient reports the introduction of the foreign body for self-therapeutic purposes. These practices remain infrequent in developing countries, especially with socio-cultural contexts, and more frequent in Western countries [3].

In our observation, our patient consulted after 5 days of introduction of the foreign body intra-recally. On the other hand, an average of 2 days is reported in the literature with intervals ranging from a few hours to a few days [1]. The main symptom is most often rectal bleeding and anorectal discomfort followed by occlusive or sub-occlusive syndrome [4]. After a careful questioning of the patient, digital rectal examination preferably under anesthesia to check the emptiness of the rectal ampulla with an abdomen without ASP preparation in search of the projection of the foreign body is essential [5]. The presence of a complication, in particular pneumoperitoneum, requires the performance of a laparotomy [6]. Apart from complications, and after confirmation of the presence of a foreign body intra-recally, endoscopic treatment remains recommended even if under certain conditions (the size of the object, the shape, etc.) the extraction of the object may be difficult or even impossible [7, 8].

Self-medication in patients followed for chronic inflammatory bowel disease is around 15% [9]. The causes of these practices are variable, ranging from the lack of means to the need for rapid relief of symptoms, which most often leads to complications represented essentially by corticosteroid dependence or resistance and rarely misuse as reported in our observation.

CONCLUSION

The insertion of foreign bodies intra-recally is a relatively rare practice in our context. Our observation illustrates one of the rare reasons for these practices, which is self-medication, and whose extraction allowed us to diagnose a chronic inflammatory bowel disease.

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