

## Intra-Rectal Foreign Bodies: About 8 Cases

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### Abstract

### Original Research Article

The introduction of foreign bodies through the anus has become a fairly frequent reason for emergency room visits (Most often voluntary, related to sexual practices). Male gender is the most concerned. The reasons for consultation are rectal discharge, abdominal pain and occlusive syndrome. ASP confirms the diagnosis if the foreign body is radio-opaque, and searches for perforation (pneumoperitoneum): emergency laparotomy. Extraction may be performed under sedation (anal extraction), or by laparotomy in the case of failure or complication.

**Keywords:** Foreign body, occlusive syndrome, abdominal pain, ASP, laparotomy.

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## INTRODUCTION

The introduction of a foreign body (FB) through the anus has become a fairly frequent reason for emergency room visits. It is rarely accidental. Males are more likely to be affected, and admission to the emergency department is only seen in cases where home extraction has failed, or where complications have arisen.

These foreign bodies are highly diverse and unusual in nature (bottle, deodorant, vegetable, etc.).

## MATERIALS AND METHODS

This work is based on a retrospective study of 8 cases of intrarectal foreign bodies treated at the Ibn Tofail general surgery department, CHU Mohamed VI of Marrakech during the period between December 2017 and December 2022.

## RESULTS

All our patients were men with an average age of 40 years, ranging from 26 to 70 years.

**Reason for Consulting:** 2 cases of occlusive syndrome, 6 cases of anorectal pain.

**Abdominal Examination:** Normal in all 3 cases.

**Rectal Examination:** Anorectal integrity and palpation of the FB in 5 cases.

**Complementary Examinations:** 7 plain abdominal x-rays and an abdominal CT scan (abdominal x-ray out of order) were performed and have revealed: TV remote

control, Betadine bottle, glass, test tube, lemonade bottle and a piece of vegetable.



FB : glass

### Treatment:

- 5 anal extractions under sedation.
- 2 surgical extractions after failure of anal extractions (sigmoidostomy/ accidental fragmentation/ extraction/ colostomy/ delayed restoration of continuity).

Simple postoperative follow-up.

## DISCUSSION

Within the situation of rectal insertion of FB, it is imperative/essential not to humiliate the patient. He must be treated with the same respect shown to other patients. This is not only ethical, but also facilitates the patient care management. The oldest report on the management of an intrarectal foreign body dates back to the 16th century [3]. 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. Other reasons include self-therapy (of constipation, hemorrhoids or anal pruritus), traumatic origin, assaults and psychiatric origin [4].

The main reasons for consultation are rectorrhagia and acute or persistent abdominal pain associated with an occlusive or sub-occlusive syndrome. Tenesmus or anorectal discomfort are also frequently cited [1]. A digital rectal examination (best performed under conscious sedation), verifies anorectal integrity and may locate the foreign body [6]. Combined with abdominal palpation, it can sometimes be used to evaluate its position [1].

If the object is radio-opaque, the diagnosis is confirmed by a plain abdomen x-ray, which shows its shape, size and position. Plants and plastic objects may remain invisible, or can be guessed from their silhouette. The abdominal radiography may also reveal pneumoperitoneum, a sign of digestive perforation, requiring emergency laparotomy. Recto-sigmoidoscopy may be attempted, paying attention not to dislodge the FB [1].

Appropriate management involves safe extraction of the object, with diagnosis of any associated colorectal lesions, which can be fatal if undetected. The foreign body can be brought down, often under conscious sedation, by gentle manipulation combined with pelvic pressure, with a view to trans-anal extraction. However, the sacral concavity and anal spasm tend to retain the foreign body away from the anus [Successful extractions have been reported, but mainly for small FBs [1].

Factors such as the size, shape and migration of foreign bodies can make it difficult to find them and extract them anally. If this fails, laparotomy may be necessary [7, 9]. Laparoscopy offers potential advantages, but has not been described in details to address this problem [11].

Laparotomy is performed in less than 40% of cases [2, 10], especially if the FB is not large. Placement of an upstream stoma depends on the degree of perineal trauma, the chronicity of the situation, and the condition

of the colorectal wall assessed intraoperatively. Finally, psychological support is necessary in all cases, up to and including psychiatric follow-up [1, 7, 8].

## CONCLUSION

- In Morocco, this remains a curiosity and a taboo.
- The patient must not be humiliated.
- Diagnosis is often easy.
- Plants and plastic objects can remain invisible, or can be guessed from their silhouette.
- Treatment depends on signs of severity and extraction conditions.

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