

The Role Of Endoscopy For Foreign Bodies In The Rectum

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Abstract

Transanal endoscopic modalities for rectal diseases have been well established (1). Retained colorectal foreign bodies are frequent, although often unreported. Patients present to the hospital only when they are unable to retrieve the object from their rectum by themselves or when they provoke colon perforations. Foreign bodies are inserted into the rectum for a variety of reasons that may be anal self-eroticism, concealment, behavioral disturbances, accidentally, or as a method to alleviate constipation (2). Patients usually attempt to remove the foreign body by themselves before seeking medical advice; the major presenting complaint is their failure to successfully remove it (3,4). Some patients often present with obscure anal or abdominal pain denying any action of foreign body insertion. In the case of colon perforation the clinical manifestations are more typical. Patients usually complain for a sudden, severe abdominal pain during insertion of the foreign body, whereas peritonitis findings may be more or less prominently present, depending on the presentation delay. Plain radiographs accurately demonstrate the location, size and type of the foreign body, and free air in the subdiaphragmatic areas can demonstrate colon perforation.

CASE REPORTS

We had four cases of rectal foreign body retention, which were successfully treated in our department. All patients were men, ages 19, 23, 66 and 51 years, corresponding. The foreign bodies included a deodorant spray, a shampoo bottle, a carrot, and a long candle respectively. The first three of them presented complaining for disability to remove the retained objects by themselves. Removal was accomplished transanally by forceps, in the operating room under general anesthesia. The last patient presented with severe abdominal pain and signs of peritonitis. He reported that he was inserted a candle during erotic games, when he felt a sudden lower abdominal pain that drew him back of any extra action, so that he immediately removed the candle. However the pain was gradually deteriorating and he presented to the emergencies six hours later. The diagnosis of colonic perforation was confirmed by demonstration of free subdiaphragmatic air in the chest radiograph. After laparotomy sigmoid colon rupture and peritonitis were revealed. Suture of the ruptured sigmoid colon and a proximal diverting colostomy were performed. The post-operative course was uncomplicated and restoration of the continuity of the colon was finally accomplished two months later.

DISCUSSION

The management and extraction of colorectal foreign bodies

can be often troublesome in the field of diagnosis, therapeutic tactics or the selection of the most suitable extraction method. Most foreign bodies can be safely retrieved transanally in the operation room under general anesthesia, as in our first three cases (3). When that is impossible to achieve or when injury of the colon is present, laparotomy is necessary and the foreign body can be extracted through a longitudinal colotomy, or it can be pushed closer to the anus to facilitate transanal extraction. In the case of colonic injury and peritonitis, a proximal diverting colostomy is mandatory. Some authors suggest a first extraction attempt in the emergency room with adequate sedation. Several procedures and devices have been employed to facilitate non-theatre removal of colorectal foreign bodies, such as anal sphincter block, obstetric forceps, Foley catheters with their tip placed proximally to the object, and flexible endoscopes equipped with a snare or a basket. In some cases however, many of these procedures may be unsuccessful because of upward migration of the foreign body or due to object characteristics (smooth surface, circular shape, etc). Additionally, minimal colonic injury may in these cases escape diagnosis (6). In such ambiguous cases a post extraction sigmoidoscopy is the best means to exclude injury or to determine its extent. Some surgeons finally suggest a combined laparoscopic and transanal approach, the laparoscopy permitting complete exploration of the peritoneal cavity in difficult cases (7,8).

CORRESPONDENCE TO

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