

# Obturator Internus Tear After Colonoscopy

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## Citation

K Turaga, S Mittal. *Obturator Internus Tear After Colonoscopy*. The Internet Journal of Gastroenterology. 2006 Volume 5 Number 2.

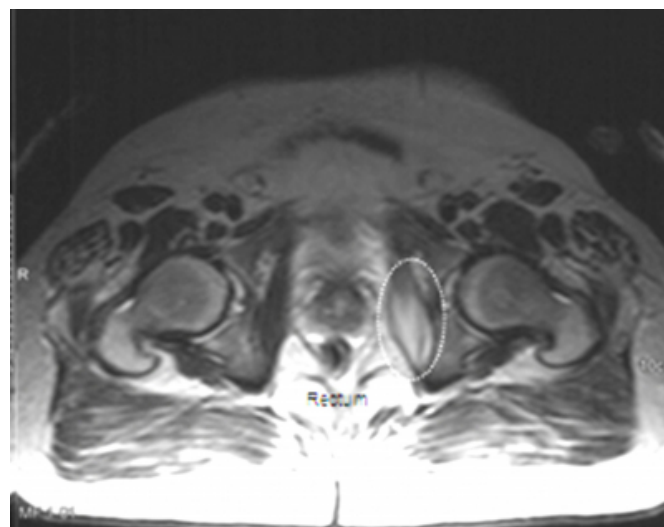
## Abstract

A 59-year-old male presented to his physician two days after a colonoscopy with complaints of severe bilateral groin pain limiting his daily activities. The colonoscopy was reported as being uneventful except for difficulty with positioning. The patient was admitted and subsequently transferred to our facility for further care after a febrile episode. The patient had severe pain with flexion of his left hip joint and a burning pain on the medial aspect of his left thigh. His past medical history was significant for hypertension and an asymptomatic pericardial effusion diagnosed several years earlier. On examination, we found an obese male with no evidence of any sensory or motor neurological deficit in his genitalia or thigh region. A rectal examination revealed no abnormality and minimal tenderness. The patient's initial evaluation with a computerized tomographic scan revealed no abnormality and a magnetic resonance imaging (MRI) study (Figure) was obtained to further evaluate the pelvis, which revealed a tear in the obturator internus muscle with edema. Blood cultures obtained on the patient after his initial febrile episode revealed gram-negative rods in two cultures. The patient had resolution of his symptoms with increasing activity, had normal bowel movements and remained afebrile on antibiotics and was discharged home.

The obturator internus muscle originates from the internal surface of the obturator foramen and the bony margins of the greater trochanter of the femur, thus, helping in abduction and lateral rotation of the thigh. It is supplied by the obturator nerve, which also provides cutaneous innervation to the medial thigh via the anterior branch. We believe that the patient sustained a microscopic rectal perforation during the procedure, which resulted in his

septicemia. The injury to the obturator muscle may have been coincidental from patient positioning. Isolated injuries to the obturator internus muscle are rare. An MRI usually determines diagnosis and treatment for this includes physical therapy and pain control. Extra-peritoneal rectal perforation created during colonoscopy can often be watched (1) and subsequent drainage procedures may be necessary.

**Figure 1**



## CORRESPONDENCE TO

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## References

1. Cobb WS, Heniford BT and Sigmon LB, et al. Colonoscopic perforations: incidence, management, and outcomes. Am Surg 2004;70(9):750,7; discussion 757-8.

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