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CASE REPORT

ACCOMODATIVE GUT: BOON OR CURSE?

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ABSTRACT: Foreign bodies inserted through anus have varied presentations and can be a diagnostic challenge as there may be delayed presentation and reluctance to give history. We report a case of 29 years old male presented with pain abdomen for 1 day and history of voluntarily insertion of a metallic foreign body for purpose of sexual gratification. After further evaluation, emergency open laparotomy was done and retrieval of foreign body from transverse colon through an enterotomy of size 10 cm length and 3cm diameter which is in cylindrical shape weighing 400gm and primary closure of transverse colon was done. Postoperative recovery was uneventful. Postoperatively these patients should be followed with rigid colonoscopy to rule out mucosal injuries due to insertion or extraction of foreign body. Diagnosis and management of foreign body inserted through anus is very challenging and should have institution specific protocols for systematic approach and management in various situations.

KEYWORDS: Foreign body in the large bowel, rectal foreign body, management of metallic foreign body in transverse colon.

INTRODUCTION: Coins, screws, nails, batteries, endoscopic cameras, glasses, chicken bones, toothbrushes, beer bottles, hair pins, safety pins, jewellery these and a lot of other foreign bodies have been retrieved in various instances from different parts of the human gut.

Definitely our gut is very accomodative!

Foreign bodies in gut have a broad spectrum of presentation with a vareity of foreign bodies located in different parts of the gut. It can be oral ingestion or insertion through anus. Intake can be accidental as in children or incidental as in psychiatric patients for purposes of sexual gratification or in case of body packers.

Typically in cases of foreign bodies inserted through anus the presentation varies from other routine cases. There may be delayed presentation after multiple failed attempts to remove the foreign body by themselves, reluctance to disclose the cause of their presentation. As a surgeon one should always consider the possibility of foreign body in bowel and evaluate accordingly and also be familiar with a variety of extraction techniques and management of colorectal injuries resulting from insertion or extraction of the foreign body.

Here we present a case of a 29 year old male with a 10x3 cm metallic foreign body inserted through anus and was managed with emergency laparotomy. In this case such a large foreign body was retrieved from transverse colon which is a very unusual site considering the distance from the anal sphincter. Patient's post-operative period was uneventful.

CASE REPORT: A 29 years old male patient presented with complaint of diffuse abdominal pain for one day and was reluctant to give any other history. On further probing he gave alleged history of

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accidental insertion of foreign body through anus one day back, following which he tried to remove it by himself multiple times and even cut his abdomen in the left lower side to remove it manually but failed. There was no history of vomitings and nausea. He passed stools once following this incident but did not pass any foreign body. On examination vitals were stable. On palpation abdomen was soft, no guarding or rigidity, no tenderness, no masses were found. On per rectal examination no foreign body was found and rest of the findings were normal.

On further investigations a cylindrical foreign body was found in the large bowel on x-ray erect abdomen [Fig. 1, 2, 3]. On ultrasound of total abdomen, there was evidence of echogenic curvilinear structure with posterior acoustic shadow in the ascending colon. Complications like peritonitis, perforation and obstruction have been ruled out.

Patient was taken up for emergency laparotomy in view of the size and position of the foreign body. A metallic foreign body of 10 cm length and 3cm diameter which is in cylindrical shape weighing 400gm was found in the transverse colon [Fig. 4]. The metallic object was removed through an enterotomy and primary closure was done with absorbable suture in interrupted single layer.

Post-operative period was uneventful and patient recovered well. No significant mucosal injuries were noted on postoperative colonoscopy.

DISCUSSION: Foreign bodies inserted through anus are rather less frequent encounters in emergency departments. Foreign bodies can be inserted in the rectum for sexual gratification or non-sexual purposes as in case of illicit drugs.[1] Numerous types of objects have been described in literature (ranging from fruits and vegetables,[2-4] cosmetic containers or bottles, batteries, light bulbs[5] and children, sex toys[6,7]) and all of these should be considered as potential hazards for causing injury. As surgeon should always remember that individuals with foreign bodies inserted through anus may be reluctant to reveal the true cause and may have delayed presentation for many hours or sometimes even days hoping for spontaneous expulsion of foreign body, sometimes they even have history of multiple failed attempts to remove the objects before visiting a doctor.[8]

Therefore a high degree of suspicion is required to arrive at the diagnosis.

Once complications are ruled out, per rectal examination should be performed to assess the distance of foreign bodies, competency of anal sphincter. Abdominal x rays should be done in view of the size, contour and position of the foreign bodies. CT scan abdomen can be considered if in doubt.

Most of the cases can be managed conservatively and other options like retrieval under anesthesia or colonoscopic retrieval or laparotomy can be considered depending on the specific case presentation.

Post operatively case should be followed up with rigid colonosopy in order to rule out musocal injury due to insertion or extraction of foreign body. Psychiatric referral should also be considered if required.

CONCLUSION: Diagnosis and management of foreign bodies inserted through anus can be very challenging. As surgeons on emergency duty we need to be aware of all the varieties of presentations and should have institution specific protocols for systematic approach and management in various situations.

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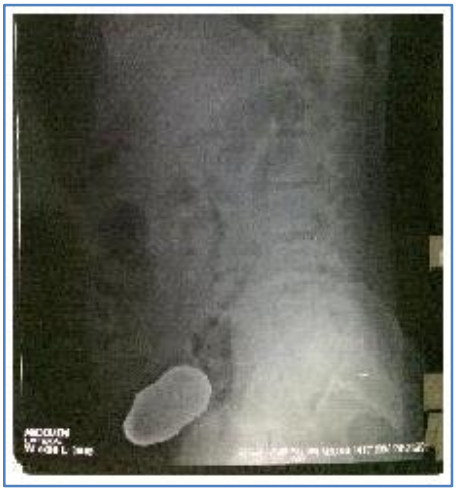

Fig. 1: x-ray of abdomen lateral view. Foreign body in rectum

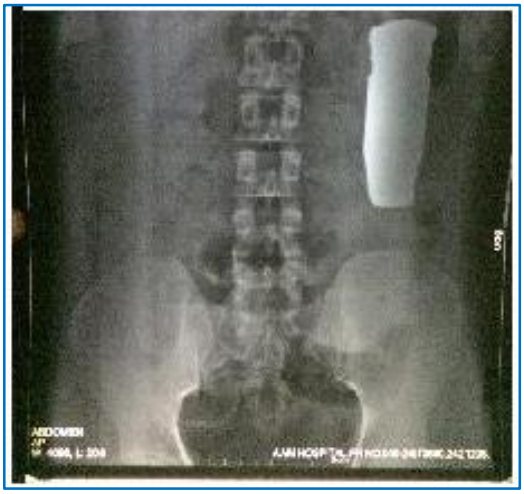

Fig. 2: x-ray erect abdomen foreign body in descending colon

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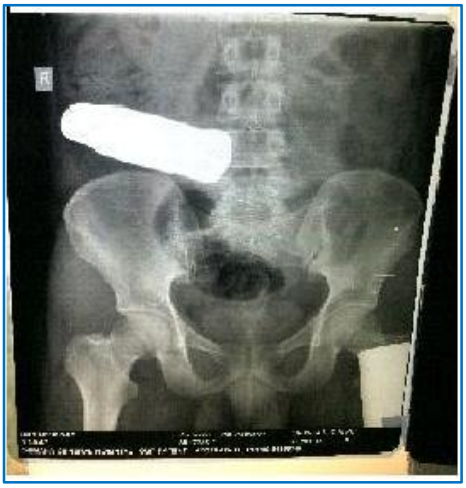

Fig. 3: X-ray erect abdomen foreign body in transverse colon

Fig. 4: Metallic Foreign body measuring 10 cm length and 3cm diameter

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