Abstract :
Foreign body in rectum are common presentation encountered as surgical emergencies. Most of the foreign body can be removed per rectum under spinal anesthesia. However some foreign body get stuck in the pelvis and requires laparotomy. Here we present a case of 55 year male came with complaint of accidental entry of a glass bottle inside his rectum while he sat for defecation. He had no signs of peritonitis. Attempts to remove it per rectum under spinal anaesthesia failed and laparotomy was performed to retrieve the object. Anterior wall of rectum opened and foreign body was removed in pieces. Then primary closure of the rectum was done. As damage to the rectum was suspected loop colostomy was done. Colostomy closure was done after 2 months. Smaller objects can be removed per rectum whereas large and sharp objects requires laparotomy to avoid further damage to anorectum and to prevent injury of surgeon's fingers.

Keyword : rectum, foreign body, sexual perversion, loop colostomy

INTRODUCTION:
Most of the foreign body are inserted per rectum for sexual perversion, criminal assault and insanity. Some of the foreign body inserted are cucumber, carrot, wooden stick, candles, small jar, vibrators. Sometimes a foreign body is swallowed, passes through the gastrointestinal tract and is held up in rectum. They feel embarrassed to reveal about the retained object in the rectum and they attempt self removal which lead to rectal damage. Foreign body rectum needs a thorough evaluation of shape, type and position of the object and early decision should be made about the retrieval of the object through laparotomy or per rectum.

CASE REPORT
A male aged 55 years came with an alleged history of accidental entry of a glass bottle of length 15cm upside down through anal orifice when he sat for defecation. He presented to the hospital 7 hours after the incidence and complained of only lower abdominal pain. He denied any further history even after repeated
interrogation. On examination patient was haemodynamically stable except tachycardia with pulse rate of 100/min. Per rectal examination revealed a glass bottle in rectum inserted upside down and mouth of the bottle found 1cm above the anal verge. No signs of abrasions or fissure was seen. No signs of peritonitis present. Per anal removal of the bottle was attempted in emergency department with a sponge holding forceps which resulted in breakage of foreign body. An emergency x ray erect abdomen was taken. It showed a glass bottle of size 15cm length X 5cm diameter upside down stuck deep in pelvis Patient was shifted to operation theatre immediately. Under spinal anaesthesia and in lithotomy position removal of the foreign body through the anal orifice was attempted but the results were futile. Patient was given general anaesthesia and lower midline laparotomy was done. On laparotomy, the glass bottle was found to be stuck in sacral hollow and mobilisation was difficult. The anterior wall of the rectum was opened and the foreign body was retrieved in pieces. All the pieces were joined together and compared with the x ray to rule out any piece of the bottle was left inside the rectum. Utmost care was taken to avoid injury to the surgeon’s hand and avoid further damage to the rectum. Primary closure of the rectum was done and as damage to the recum was suspected a sigmoid loop colostomy was fashioned. After 2 months of period barium enema study was done. No obstruction in the rectum was present. Reversal of the colostomy was done and the patient passed stools via naturalis.

**preoperative patients photo**

comfortable in lateral decubitus position, not able to sit or stand erect xray abdomen showing glass bottle inserted upside down into rectum attempts were made to remove the foreign body per rectum diagrammatic representation of foreign body in rectum foreign body retrieved in pieces retrieved pieces joined together retrieved pieces compared

with the bottle in the x ray patient's photo with colostomy after 2 months
picture after colostomy closure

DISCUSSION

EPIDEMIOLOGY:
Prevalence is higher in males than in females by a ratio of 28:1. Most of the patients are in the age range of 20-30 years. Rectal foreign bodies are usually inserted per anum, with the vast majority of cases as a result of sexual perversion. It may be also associated with sexual assault or smuggling or insanity.

PATHOPHYSIOLOGY:
Rectal foreign bodies can be classified as

- high-lying or
- low lying.

Delay in presentation to the hospital because of social embarrassment and multiple attempts of self-removal will lead to mucosal edema and muscular spasms. Rectal lacerations and perforations are common if sharp foreign bodies are inserted. In children, the ingested foreign bodies like pins, coins, fish bone, wooden thorns etc can pass through the whole GIT uneventfully and get stuck in the ano rectal region. Objects that are above the sacral curve and rectosigmoid junction are difficult to visualize and remove.

INVESTIGATION:
- X-ray erect abdomen
- Rectosigmoidoscopy

MANAGEMENT:
Low lying small foreign body in rectum could be removed in emergency room if it could be visualised and grasped. For high lying foreign body visualisation and removal can be done by using flexible rectosigmoidoscopy under general anaesthesia. In difficult case like ours laparotomy and retrieval is the only choice left over. Laparotomy is mostly required for foreign bodies that are
reaching the sacral curvature, the objects that are sharp and large. Patient is put in lithotomy position to allow for both abdominal and perineal access. Removal of the foreign body and primary closure is the usual procedure done. Diversion procedure is indicated if the rectal damage is suspected and rectal viability is doubtful. Adequate management is not only removal of the foreign body but include the following factors. Privacy of the patient should be respected. Proper evaluation of the type and location of the foreign body should be done before attempting the removal of the foreign body. Determine whether the foreign body can be removed in the emergency room or the patient needs operative referral. Appropriate techniques for removal should be employed. Psychiatry counseling is essential so that the same kind of activity shall not be repeated. Any attempt to remove the foreign body in GIT should be attempted only in a centre where all facilities for evaluation and removal are available. Self removal or partial removal in peripheral centre may endanger the life of the patient.

CONCLUSION: 1. Rectal foreign bodies is usually due to some sexual activity. 2. Possibility of sexual assault should be kept in mind. 3. Foreign bodies are mostly low lying and small sized. 4. They are most commonly removed through anal orifice. 5. Laparotomy is indicated only in rare cases.

REFERENCES