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RECTAL FOREIGN BODY REMOVAL UNDER GENERAL ANAESTHESIA

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ABSTRACT

Background: Rectal foreign bodies are a rare but serious surgical emergency that can lead to serious problems if they aren't diagnosed or treated right away. Early evaluation and the right action are necessary to avoid illness.

Case Presentation: We present a patient who arrived at the emergency department with rectal discomfort after the insertion of a foreign body per rectum. The patient was stable in terms of blood flow and had no signs of peritonitis. A plain abdominal X-ray showed a foreign body that was not visible on the X-ray and was in the rectum, but there was no sign of a bowel perforation. The foreign object was successfully taken out through the anus while the patient was under general anaesthesia, so there was no need for surgery. There were no problems during or after the surgery.

Conclusion: This case shows that early diagnosis, the right imaging, and timely trans anal extraction under general anaesthesia can all lead to successful non-operative management of rectal foreign bodies. A structured and multidisciplinary approach is important because it makes sure that the patient is relaxed enough for the surgery to be safe and lowers the risk of iatrogenic injury.

INTRODUCTION

In emergency and colorectal surgical practice, putting a foreign body in the rectum is a rare but well-known way to present. Recent literature indicates a gradual rise in cases presenting to emergency departments globally, although the actual incidence is challenging to ascertain due to patient hesitance and underreporting. These presentations are predominantly observed in adult males and are often linked to sexual practices, psychiatric disorders, substance abuse, or accidental insertion. Patients may exhibit symptoms varying from mild rectal discomfort and tenesmus to severe complications, including bowel perforation, hemorrhage, peritonitis, and sepsis, especially when presentation is delayed.

The first step in evaluating patients who may have rectal foreign bodies is to carefully check their clinical status, paying special attention to their hemodynamic stability and making sure they don't have peritonitis. Imaging is a key part of management. Plain abdominal radiography is still a useful first-line test, especially for radiopaque objects. It can help figure out the size, shape, and location of the foreign body and look for signs of perforation, such as free air in the peritoneum {1,4}. Computed tomography is only used when complications are suspected or when plain radiography doesn't give a clear answer {3}.

The management strategies are based on where the foreign body is in the body, what it looks like, and whether or not there are any problems. For stable patients with low-lying rectal foreign bodies and no signs of perforation, trans anal extraction is the recommended first step {2}. Numerous studies have shown that early intervention with general anesthesia greatly increases the chances of successfully removing the object without surgery by relaxing the anal sphincter, making the patient more comfortable, and lowering the risk of rectal injury caused by medical care {4,5}. Surgical intervention is generally reserved for unsuccessful transanal attempts or instances complicated by perforation or peritonitis.

Case Presentation

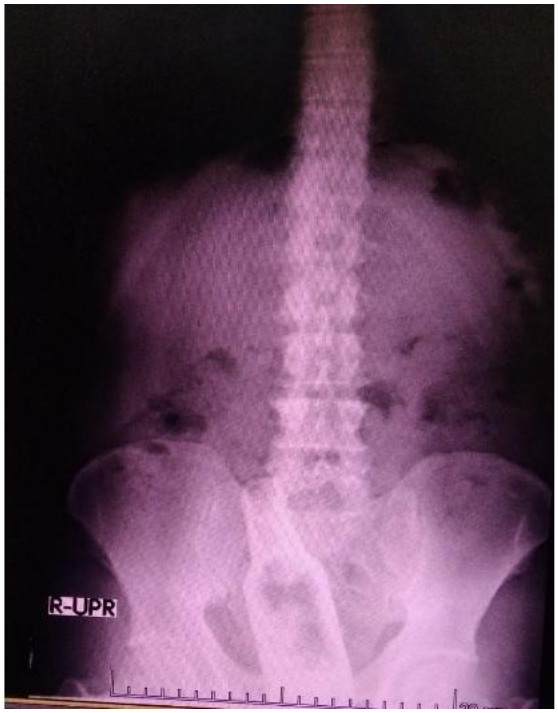
A patient came to the Emergency Department of Dr. Sikandar Ali Mandhro Hospital in Badin, which is part of the Indus Hospital Network. They had a history of putting something foreign in their rectum. The patient said they were having trouble getting the thing out of their rectum by themselves. There was no previous history of abdominal pain, rectal bleeding, vomiting, or fever at the time of presentation. The patient quickly went to the doctor after failing to get away from themselves.

At first, the patient's vital signs were normal, and their blood flow was stable. The stomach exam showed that the stomach wasn't hard, tender, or guarding, and it wasn't swollen. There were no signs in the clinical setting that pointed to bowel obstruction or peritonitis. At first, the digital rectal exam was put off because there were worries about the foreign body's nature, which was thought to be hard or possibly sharp, and to avoid the risk of iatrogenic rectal injury.

There were tests to start with. A simple X-ray of the abdomen and pelvis showed a foreign body that could not be seen on X-ray inside the rectum. The X-ray did not show any signs of free air in the abdomen, a blocked bowel, or a hole in the bowel. Based on the clinical and radiological findings, the decision was made to proceed with the removal in a controlled operating room environment. The patient was moved to the emergency operating room for the last time. While the patient was under general anaesthesia, they were put in lithotomy. After the patient was properly sedated with anaesthesia, a careful rectal exam was done. It was easy to take out the foreign body by hand through the transanal route. No incision or endoscope assistance was necessary.

After the extraction, there were no signs of injury to the rectal mucosa, bleeding, or perforation. The patient remained stable throughout the procedure and the recovery period. He was watched after surgery as part of his normal care, and his recovery went well, with no problems right after surgery. **(Figure 1)**

Figure 1. Plain abdominal radiograph demonstrating a radiopaque foreign body located within the rectum, with no evidence of bowel obstruction or free intraperitoneal air.



DISCUSSION

Due to delayed presentation, social stigma, and differences in object characteristics, rectal foreign bodies continue to be hard to diagnose and treat. To avoid serious problems like rectal perforation, pelvic sepsis, and the need for emergency laparotomy, it is important to quickly assess and organize treatment. Recent research shows that the most important things that affect the outcome are when the presentation happens, where the foreign body is located, and how it is removed {6}.

Imaging is very important for deciding how to run things. Plain abdominal radiography is still the best way to find foreign bodies that don't show up on X-rays. It shows doctors where the object is, how big it is, and how it is orientated, and it also rules out pneumoperitoneum {7}. When perforation is suspected or when plain radiographs don't give clear results, especially in high-risk or delayed cases, computed tomography is recommended [8]. In this case, plain radiography was able to find the foreign body and rule out any complications, making it safe to move on to trans anal removal.

Current evidence suggests that trans anal extraction should be the first choice for clinically stable patients who do not show any signs of peritonitis. When early intervention is used, the success rates for non-operative removal have been reported to be higher than 70–80% {9}. General anesthesia is very important for making extractions more successful because it relaxes the anal sphincter, makes the patient more comfortable, and gives the doctor better control over the procedure, which lowers the risk of mucosal

injury or perforation {10}. This method worked very well to get the extraction to work in this case without needing endoscopy or surgery.

When trans anal methods don't work or there are problems like perforation, uncontrolled bleeding, or peritonitis, surgery is the only option. Research shows that the most important factor in needing surgery and having bad outcomes is waiting too long to see a doctor {6,9}. It is very important to check and keep an eye on the area after the extraction because hidden injuries may not be obvious right away. In some cases, an endoscopic evaluation may be necessary, but it is not required for all uncomplicated presentations {11}.

This case shows how important it is to get a quick diagnosis, the right imaging, and the right treatment under general anesthesia. All these things can lower the risk of complications and avoid unnecessary surgeries.

Conclusion

Foreign objects in the rectum are a difficult but treatable surgical emergency if they are detected early and dealt with in a methodical manner. The case has shown that early clinical evaluation, proper imaging and timely intervention under general anesthesia can help in easy removal of the anal without surgical exploration. Sufficient sphincter relaxation brought about by general anesthesia is important in ensuring ease of procedure as well as minimizing the risk of iatrogenic injury. Close postoperative care is always necessary to overcome the presence of occult complications. Non-operative management that is applied at an early stage can achieve positive results and avoid unwarranted morbidity.

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