

## CASE NOTE

# Intussuscepted intestine through a rectal foreign body

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**R**ectal foreign bodies are an unfortunate source of both humour and clinical intrigue for the surgical community. Since their initial description in the 16th century, their management has evolved substantially.<sup>1</sup> Assuming a patient does not present with peritonitis, the therapeutic algorithm typically begins with sedation and a bedside attempt at extraction.<sup>2,3</sup> Failing this, the patient is transferred to the operating room for an examination under anesthesia with transanal extraction. Because these techniques are usually successful, a laparotomy is required in less than 10% of patients.<sup>3</sup>

In addition to this sequence of events aimed at removing retained foreign bodies, numerous individual techniques have also been described. These include, but are not limited to, the use of polypectomy snares, forceps, inflated Foley balloon catheters, obstetric vacuum extractors, achalasia/dilation balloons and even plaster casts.<sup>4</sup> Predictors of failure, or conversely of requiring a laparotomy for extraction, include objects that have migrated into the sigmoid colon as well as those that have been retained for more than 2 days.<sup>3</sup> This is predictable given the high likelihood that most patients attempt to remove foreign bodies themselves before seeking medical advice.<sup>4,5</sup> As a result, the true incidence of this dilemma is unknown.

**CASE REPORT**

A 50-year-old man with a history of HIV and hypertension presented to our centre with a retained foreign body in his rectum. He was unable to adequately describe the object, but did offer a 12-hour history of retention. On examination his lower abdomen was moderately tender. The remainder of his assessment was unremarkable, including normal vital signs and laboratory test results. The object was not palpable on digital rectal examination, nor radiopaque on abdominal radiography. On bedside proctoscopy using a rigid sigmoidoscope, a circular plastic object appeared to be locked at the upper margin of his rectum (25 cm from the anal verge). There also appeared to be a concurrent rectal intussusception through the centre of the retained body. Extraction using large biopsy forceps was unsuccessful at both the bedside and during an examination under anesthesia. Furthermore, it was impossible to pass any device or balloon catheter proximal to the object itself.

At laparotomy, we noted a dual intussusception of both his sigmoid colon (15 cm) and small bowel (30 cm; Fig. 1 and Fig. 2). Although the small bowel appeared viable after reduction from the rectum, 10 cm of intussuscepted distal sigmoid colon was ischemic and perforated. We resected this colonic segment with the assistance of a gastrointestinal stapling device. Given the patient's intraperitoneal fecal contamination, the distal position of the resection margin and an extremely patulous anus, we completed a diverting end colostomy. The patient recovered bowel function within 4 days and was discharged home without complication.

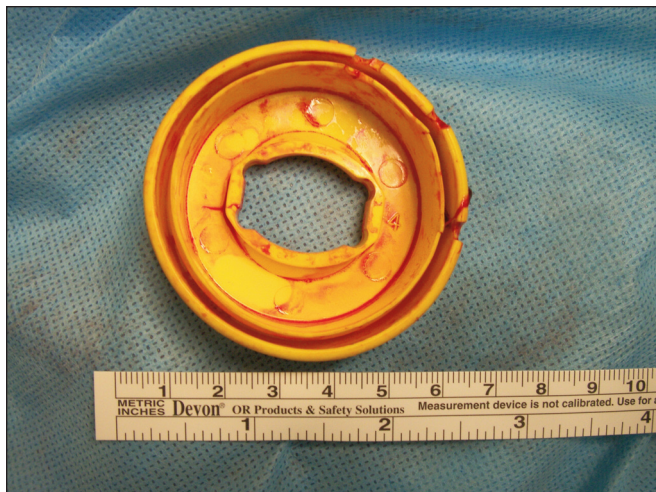


Fig. 1. Retained rectal foreign body in a 50-year-old man.

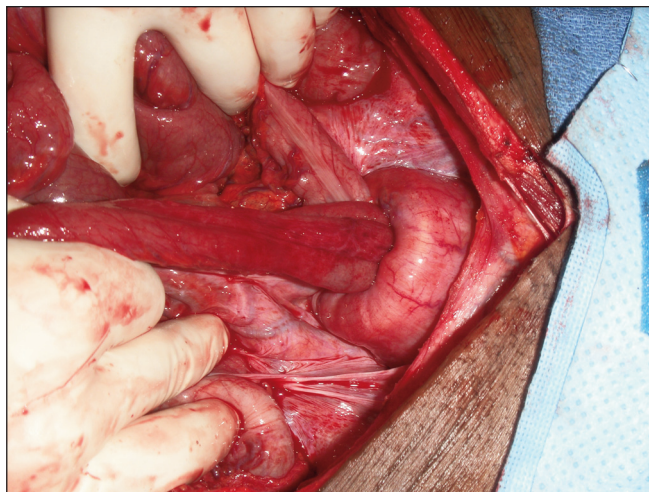


Fig. 2. Intussuscepted small intestine and sigmoid colon through the retained foreign body.

## DISCUSSION

The varied reasons for insertion of a rectal foreign body are well documented.<sup>2,3</sup> These include criminal assault, self-treatment, sexual gratification and even the occasional accidental endeavour. Although most objects can be extracted using manoeuvres at the bedside (75%) or under anesthesia (88%), our patient required a laparotomy to reduce the intussuscepted bowel and colon.<sup>3</sup> Once reduced, we manually ejected the object through the patient's patulous anus without an additional colotomy. This represents an extremely rare but interesting version of the classic retained rectal foreign body scenario.

**Competing interests:** None declared.

## References

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