

CASE REPORT

Delayed Presentation of Rectal Foreign Body with Rectal Perforation & Sacral Osteomyelitis: A Case Report

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ABSTRACT

Anorectal foreign bodies though rare have become increasingly frequent in recent years. The majority of cases reported in the literature pertain mostly to sexual abuse or sexual pleasure. These occurrences cause complications such as abscesses, perianal fistula & osteomyelitis. We are reporting a unique case of rectal foreign body that occurred due to trauma some 20 years ago. The mode of trauma was a fall from a tree (approx. 9ft) in childhood at the age of 8 years with an impact on the lower abdomen. Historically, the patient had evisceration of the gut was managed surgically (explorative laparotomy with the closure of the abdomen). Patient reports to the colorectal outpatient department at the age of 28yrs with chief complaints of pus discharge per rectally & low back ache (on/off) with radiological investigations (MRI PELVIS) s/o foreign body in right pre sacral space & small perforation in post upper rectum with sacral osteomyelitis.

There is a progressive rise in hospital presentation of impacted rectal foreign bodies with an increase in the incidence of erotical/sexual objects. The case is of a retained foreign body from accidental/childhood injury. This case presented with symptoms of persistent pus discharge & low back ache which upon evaluation further revealed on MRI s/o foreign body in right perirectal space and sacral osteomyelitis.

These cases must be handled as complicated cases & must be considered in terms of systemic treatment approach & not as cases needing local treatment.

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INTRODUCTION

Rectal foreign bodies represent a diverse & challenging field of colorectal trauma.² Various causes of foreign body rectum include sexual abuse/pleasure, very rarely it may occur due to a forgotten instrument during previous surgery or due to trauma with impact to the abdomen or perineum. In cases of multiple trauma injuries with involvement of both the abdomen and perineum, foreign bodies may be missed and left in situ during surgical exploration in the emergency OR due to the confines of pelvic anatomy. The detection & diagnosis of rectal foreign bodies includes a meticulous multidimensional approach including history & physical examination, a high index of suspicion for e/o any perforation, a creative approach to non-operative removal & appropriate follow-up to detect any delayed perforation.³

CASE PRESENTATION

28-year-old male patient with no underlying comorbidity

presented with complaint of pus discharge per rectum & Lower back ache (on/off) x 1yr. On eliciting detailed history from the patient, the patient had abdominal blunt trauma due to a fall from a tree with evisceration of the gut at the age of 8 years. The patient underwent explorative laparotomy at the time (operative records not available). There was no history of fever, bleeding PR, faecal or urinary incontinence.

Physical examination was grossly normal.

DRE WITH PROCTOSCOPY: No external opening /no fissure. Anal tone increased. No growth or pile mass felt, no internal opening or any fistulous tract.

COLONOSCOPY: whitish discharge coming out from the opening in the rectum, the mucosa is edematous & vascular marking is lost. Fistulous tract draining into the rectum.

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CE MRI PELVIS: Evidence of a large linear T1/T2/STIR hypo intense foreign body measuring 10cms in length & 1.2cms in width is seen in presacral space, placed diagonally obliquely with surrounding T2/STIR hyper in post-contrast peripheral enhancement. Associated T2/STIR hyper intensity is seen in the right sacral ala with subtle heterogeneous post-contrast enhancement consistent with osteomyelitis. No definite perianal fistula or collection was seen. Consultations were sought from another department as well, Orthopedic consultation for sacral osteomyelitis, infectious disease in view disease of chronic pus x1 yr (panel of tests for infectious diseases were negative), and Neurosurgery consultation for spine involvement.

After all evaluation, the operative plan was made and consent was taken for stoma formation. The patient was operated on under GA, after putting in a supine & lithotomy position.

OPERATIVE PROCEDURE: Examination under anesthesia with explorative laparotomy with coccygectomy with partial gastrectomy with excision of granulation tissue with diversion sigmoid loop colostomy. Intraoperatively no foreign body was retrieved.

DISCUSSION

Foreign bodies in the rectum if left in situ or forgotten pose a major challenge both for the attending surgeon & patient. The reason behind this may be attributed to non-seeking of medical attention for quite a long time due to social embarrassment, inadequate counselling by the treating doctor in case of previous surgery for abdominal or perineal trauma for maintenance of follow-up, poor compliance of patient or his family, psychiatric issues etc.⁴

Foreign bodies in the rectum occur due to erotical behavior, sexual violence, abdominal & perineal trauma etc. Clinical presentation includes perineal pain, formation of perirectal abscess &/or fistula, bleeding PR, Pus discharge, urinary or faecal incontinence, osteomyelitis & systemic sepsis.⁵ Foreign bodies can be of different objects & different sizes & can be made up of plastic, aluminum, and glass. Larger ones cause more complications.⁶ Management of these cases must be dealt with meticulously with proper evaluation including a thorough history and physical examination with radiological investigations & involvement of other specialties as well including colorectal physicians, orthopedics, spine surgeons etc. There are

various methods for the retrieval of foreign bodies in the rectum and anus. Several studies reported that the majority 90% of the cases is treated by trans anal retrieval and routine laboratory investigation and abdominal images are unnecessary. The foreign bodies that are lodged inside the anal canal can be retrieved transanally. The foreign bodies that are lodged higher up in the rectum are retrieved Trans abdominally. In our case, the MRI suggested a foreign body in the perirectal space behind the upper rectum. We used a transabdominal approach and intraoperatively no foreign body was retrieved. Examination under anesthesia was done and a colostomy was made.

CONCLUSION

There is a progressive rise in hospital presentation of impacted rectal foreign bodies with an increase in the incidence of erotical /sexual objects. This is a case of retained foreign bodies from accidental/childhood injury. This case presented with symptoms of persistent pus discharge & low back ache which upon evaluation further revealed on MRI suggested of foreign body in the right perirectal space, and sacral osteomyelitis. The patient was managed surgically by transabdominal approach and temporary colostomy was made and debridement was done for sacral osteomyelitis. However, no foreign body was retrieved intraoperatively.

These cases must be handled as complicated cases & must be considered in terms of systemic treatment approach & not as cases needing local treatment.⁷

ETHICAL CONSIDERATIONS

Consent: Taken

Conflict of Interest: None

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COMPLIANCE WITH ETHICAL GUIDELINES

There were no ethical considerations to be considered in this research.

Authors Contributions

All authors equally contributed in preparing this article.

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