

'Radish' in the rectum

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ABSTRACT •

A 38 years male was referred to our hospital for sigmoidoscopy and removal of foreign body from rectum. Patient gave history of insertion of 'radish' through his anus. He developed pain, distension, vomiting and obstipation next day. On presentation abdomen was board like rigid and distended. He underwent emergency laparotomy and removal of radish from pelvis. He had eventful post operative days. He didn't disclose why he inserted radish into his rectum!

Keyword: foreign body, perforation, radish, rectum

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Introduction

Foreign body within the rectum occur infrequently.¹ A variety of foreign objects may be introduced into the alimentary tract either accidentally or deliberately.² Insertion of foreign bodies into rectum is usually for diagnostic or therapeutic treatment, criminal assault, self administration treatment, and autoeroticism.³ Foreign bodies in rectum may result complications such as obstruction, ulceration, bleeding and perforation.^{1,2,4} Often patients are reluctant to seek medical help initially and they themselves attempt to remove foreign body multiple times and so delay in presentation occurs.⁴ Removal of rectal foreign bodies are challenging to clinicians. They should be seriously and expeditiously treated.¹ Here we report one unusual rectal foreign body with its complications and management.

Case

A 38 years male patient was referred to our hospital for sigmoidoscopy and removal of foreign body i.e. 'radish' from the rectum. He gave history of being seen in emergency department of a teaching hospital in town for pain, distension of abdomen, vomiting and unable to pass stool and flatus for three days following insertion of radish in his rectum one day prior to presenting in that hospital. The notes from emergency department of that hospital mentioned pulse (P) of 120/min, blood pressure (BP) 120/70 mmHg, and abdomen pain with guarding, distension of abdomen. Next day patient was referred to us with sick look, irritable, P 138/min, fever of 101 °F, BP 90/60 mmHg and respiration (R) 26/min. There was tenderness, guarding, distension and board like rigidity of whole abdomen. Laboratory parameters were normal. After resuscitation emergency laparotomy was performed same day. Radish was found in the pelvic cavity with 400 ml faecal contaminated dirty fluid. A rectal perforation of 5x4 cm at 8 cm from anal verge was found. Peritoneal lavage, repair of rectal perforation and loop sigmoid colostomy was done. On 8th post operative day patient developed burst abdomen. Relaparotomy and tension suturing was done. During surgery bilateral subdiaphragmatic pus was found. Pus culture grew *E.coli*, *K. pneumoniae*, *P. aeruginosa*. Antibiotic was adjusted accordingly. Patient stayed in hospital for 39 days and was discharged with functioning colostomy. Reversal of colostomy was done successfully three months later. On follow up patient had no complain. He did not disclose

the reason for insertion of radish. He was advised to seek psychiatric consultation.

Discussion

Rectal foreign body may present with pain, bleeding, obstipation, abdominal pain and distension, mucus discharge, incontinence, and peritonitis as in our case. It is reported less commonly from Asia and majority of case series are from Eastern Europe.¹ The objects found in the rectum and sigmoid colon range from bottles, test tubes, candle, umbrella handle, platinum encased in a condom, glasses, fruits, vegetables, broom handles, dildos, vibrators, torches, screwdrivers, spectacles, dentures, pen-knives and fish hooks.^{1,3,4-7} Foreign bodies are introduced into rectum mostly for sexual stimulation and autoeroticism. Other causes are assault, accidents, alleviation of constipation, prostatic massage and diagnostic as well as therapeutic purposes.^{1,3,4,6-8} Butters reported that a 24 years man lighted firecracker in a tube inserted through his anus creating a large hole in the anterior wall of the rectum.⁹ He survived surgery and got psychiatric treatment. Wagner mentions some of the earlier report of interesting cases.¹⁰ Foreign bodies are lodged in the rectum because of shape (tapered at one end and wider at other), the anal sphincter mechanism, and inserted deeper than intended to achieve greater stimulation.⁵

Males are affected more than female with ratio of 28 to 1.⁷ Age group 16 to 80 y is seen commonly with bimodal observation of eroticism in younger and for breaking faecal impactions in older age.^{6,7,11} Usually patients present late because initially they try to remove the objects themselves and are reluctant to disclose history of foreign body insertion.^{4,6} High index of suspicion is needed for diagnosis. History, digital rectal examination (DRE), x-rays, and sigmoidoscopy are helpful.^{3,8} X-ray of abdomen and pelvis may help in localization and to determine site, shape and nature of objects. In case of suspicion and doubtful history, x-ray should be done before DRE to prevent accidental injury to surgeon from sharp objects.

Transanal retrieval is successful in majority (90%).^{1,11} Care should be taken to prevent trauma due to sharp objects and migration upwards during manipulation. Sometimes abdominal manipulation and stabilization helps in retrieval of foreign bodies.¹ Obstetric forceps, biopsy forceps, snares, Foley's catheter or colonoscopy

are helpful to retrieve foreign bodies.^{1,6} Laparotomy with or without diversion colostomy is required to retrieve impacted foreign body and when there is already features of perforation peritonitis. Pubic symphysiotomy to widen pelvis and allow trans-anal extraction of foreign body (an oval shaped marble) has been reported.⁴ Proctosigmoidoscopy is required to rule out extent of mucosal lacerations, bleeding, perforation or missed foreign body even after 'successful removal' through anus.^{1,4} Most of the patients present late because of embarrassment. Important point in care of these patients is to refrain from making 'satirical' remarks and respect patient's privacy and integrity.

Conclusion

Laparotomy, primary repair of rectal perforation and prophylactic defunctioning loop sigmoid colostomy was successfully performed for perforation peritonitis following insertion of radish through anus. Patients with foreign body present late due to embarrassment.

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Figure 1.

Laparotomy revealing radish in pelvis



Figure 2.

Rectal perforation caused by radish inserted through anus



Figure 3.

Radish removed after laparotomy, 16 x 6 cm



Figure 4.

Completion Loop sigmoid colostomy after repair of rectal perforation

