



Rectal Foreign Body for to Self-Inflicted Anal Eroticism in Man: Clinical Case



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Abstract

Background: Historically, the acceptance of anorectal sexual practices has varied throughout different civilizations. While he was condemned in biblical times, anal intercourse was often practiced by the Greek and Roman civilizations. Due to the current changes in sexual behavior, the surgeon is currently facing new problems in the diagnosis and treatment of rare rectal lesions.

Clinical case: Male 37 years-old, married who presents to the emergency room complaining of pain in posterior anorectal area to the introduction of a foreign body, the patient reports attempted manual removal at home by maneuvers Valsalva unsuccessfully. Patient with stable vital signs and physical examination, normal chest and abdomen and rectal exam glass object is palpated proximal end with metal, plain abdominal radiography is requested where is evident the intraanal object.

Laboratory test normal: Manual removal is attempted in emergencies without success due to the caused pain and decided to pass to the operating room where under spinal block and position in Sevillian razor a curve clamp rings is used and removal of the foreign body is achieved without difficulty.

Discussion: Retained rectal foreign body is not an uncommon condition, but reliable epidemiological data are not available. The aim of the clinical evaluation is to identify the type, number, size, shape and location of the foreign body. Removal of retained rectal foreign bodies requires experience, with particular attention to different methods of extracting various objects. It is mandatory to perform a proctosigmoidoscopy after anorectal foreign body removal to exclude bowel injury and ensure that the patient has not inserted more than one foreign body. Patients with mucosal abrasion, tears and edema are to be admitted for a period of observation.

Conclusion: These cases are sporadic presentation in our medium one case or less for about a year and our patient quickly came to the emergency room for care, just as the size and shape of the pot perfume not allowed to advance beyond the rectum it which facilitated its removal under regional anesthesia without suffering further damage.

Keywords: Rectum; Foreign bodies; Extraction methods; Diagnostic; Treatment

Background

Historically, the acceptance of anorectal sexual practices has varied throughout different civilizations. While he was condemned in biblical times, anal intercourse was often practiced by the Greek and Roman civilizations. In the middle Ages, he was sentenced to death at the stake. Due to the current changes in sexual behavior, the surgeon is currently facing new problems in the diagnosis and treatment of rare rectal lesions. It is being observed in recent years in the Emergency Services, but also but less frequent cases increased introduction of foreign bodies in the rectum, especially unusual sexual practices, for criminal reasons or drug trafficking. One of the earliest case reports as published in 1919, although Haft and Benjamin referred to a case as long ago as the sixteenth century. Colorectal foreign bodies (CFBs) are not an uncommon

presentation to the emergency or colorectal surgery department, and some authors have suggested that the incidence is increasing.

Objects can be inserted in to the rectum for diagnostic or therapeutic purposes, self-treatment of anorectal disease, during criminal assault or accidents, or (most commonly) or sexual purposes. One of the most common problems encountered in the management of rectal foreign bodies is the delay in presentation, as many patients are embarrassed and reluctant to seek medical are most of these patients present to the emergency room after efforts to remove the object at home. Moreover, in the emergency room, patients may often be less than truthful regarding the reason for their visit, leading o extensive workups and further delays. Even after extraction, Delayed perforation of or significant bleeding from

the rectum may occur. Hence, a stepwise approach that includes diagnosis. Removal and post extraction evaluation is essential [1,2].

Clinical Case

Male 37 years old, married who presents to the emergency room complaining of pain in posterior anorectal area to the introduction of a foreign body (container perfume), the patient reports attempted manual removal at home by maneuvers Valsalva unsuccessfully. Patient with stable vital signs and physical examination, normal chest and abdomen and rectal exam glass object is palpated proximal end with metal, plain abdominal radiography is requested where is evident the intraanal object (Figure 1). Laboratory test normal. Manual removal is attempted in emergencies without success due to the caused pain and decided to pass to the operating room where under spinal block and position in Sevillian razor a curve clamp rings (Foester) is used and removal of the foreign body is achieved without difficulty. For monitoring the patient is entered in the hospital and the next day requested voluntary discharge.



Figure 1: Plain radiograph demonstrating rectal foreign body.

Discussion

Retained rectal foreign body is not an uncommon condition, but reliable epidemiological data are not available. The aim of the clinical evaluation is to identify the type, number, size, shape and location of the foreign body. Removal of retained rectal foreign bodies requires experience, with particular attention to different methods of extracting various objects. It is mandatory to perform a proctosigmoidoscopy after anorectal foreign body removal to exclude bowel injury and ensure that the patient has not inserted more than one foreign body. Patients with mucosal abrasion, tears and edema are to be admitted for a period of observation [3].

Odagiri H et al. [4] in totals of 648 RFB patients with 666 presentations was identified during the study period. The incidence of a RFB was most frequently seen in males who were in their 60s and in females who were in their 80s. The overall in-

hospital mortality was 1.2%. Compared with males, females had a significantly higher proportion of in-hospital death (0.4 vs. 4.8%), perforation and peritonitis (5.2 vs. 12.8%), and sepsis (1.1 vs. 4.0%).

Camacho Aguilera et al. [5] analyzed the clinical records of 33 patients; most were men (93.9%), the most frequent introduced foreign body were flasks (42.4%), followed by wooden sticks (12.1%). The most frequent etiology was insertion due to self-inflicted anal eroticism (54.5%), accompanied by alcohol and/or drug abuse (33.3%) and localization at less than 10cm from the anal margin (69.9%). Frequent manifestations are: foreign body sensation, abdominal distension, transanal pain, abdominal pain, and constipation. Extraction was performed by transanal approach (75.6%) and by exploratory laparotomy (24.2%). Evolution was satisfactory in 29 patients; four patients developed peritonitis and in three patients the peritonitis evolved and led to death. Coinciding with our case about sex, at a distance from the anal margin and the purpose of the introduction the object.

Subbotin VM et al. [6] during the 22 years period there were 26 patients (23men and 3women) aged from 18 to 71 with foreign bodies in the rectum introduced through the anal canal. The main causes of the appearance of foreign bodies in the rectum were anal masturbation (in 12 patients) and forced introduction of the objects by other people (in 10 patients). Typical were large sizes of the most objects introduced (the diametrical size more than 6cm and the length more than 15cm) which was responsible for the development of complications and made the removal difficult.

Buczyński J et al. [7] report that a foreign body in the rectum is not a very common emergency case in surgical practice, of various etiologies. In the years 2003-2011, 8 people were hospitalized in the Clinic of General and Colorectal Surgery due to a foreign body in the rectum. All the patients were male. All of them were qualified for foreign body removal in a surgical suite, under general anesthesia due to a potential need for expanding the scope of the procedure. In all situations attempts were made at removing the object through the anus, which proved successful in 7 cases, without complications. In one case the scope of the procedure needed to be expanded with laparotomy and sigmoidotomy, through which the foreign body was removed.

Kurer MA et al. [8] perform a systematic review of the published reports on retained colorectal foreign bodies (CFBs) to collate the features and formulate a simple management plan based on the available evidence and this review covers a total of 193 patients with 196 presentations. There were 188 men and 5 women, a ratio of approximately 37:1. The mean age at presentation was 44.1 years in the single case reports and 39.3, 40 and 60.8 years in the three case series.

Rodriguez & Hermosa JI et al. [9] from 1997 to 2004, data were collected prospectively in 30 patients (20 men and 10 women. Extraction method, size and type of object, and post extraction evolution were reviewed. The FB was introduced anally in 16 cases

and by oral ingestion in 14. Principal associated factors were: Mental disorder in 11, penitentiary confinement in two, and drug and alcohol intake in two. Recent sexual activity had taken place in 14 cases. Treatment consisted of spontaneous ejection (n=2), digital extraction with or without enemas (n=10), digital extraction under local/regional anesthesia after fragmentation (n=11) and regional exploratory laparotomy under general anesthesia (n=7).

Lim KJ et al. [10] reports that two cases of rectal foreign body removal by a relatively simple and inexpensive technique. A 42-year-old man with a vibrator in the rectum was admitted due to inability to remove it by himself and various endoscopic methods failed. Finally, the vibrator was removed successfully by using tenaculum forceps under endoscopic assistance.

On the other hand, transanal use of a SILS port has been reported for excision of rectal tumors as an alternative to transanal endoscopic microsurgery. Various investigators have claimed advantages of better visualization, cost savings, and improved operating room time when using the SILS port for performing transanal excisions of rectal tumors. Compared to more-invasive means of rectal foreign body extraction, transanal use of the SILS port offers the potential for less postoperative pain. In addition, hospital admission can likely be avoided, ultimately resulting in lower overall hospital costs [11].

Sadhu S et al. [12] describe a 64-year-old male patient presented with rectal symptoms, and a rectosigmoid foreign body was discovered after 35 days of self-insertion. No serious life threatening events occurred during this period. This was easily removed by trans-anal approach under anesthesia.

Conclusion

These cases are sporadic presentation in our medium 1 case or less for about a year and our patient quickly came to the emergency room for care, just as the size and shape of the pot perfume not allowed to advance beyond the rectum it which facilitated its

removal under regional anesthesia without suffering further damage.

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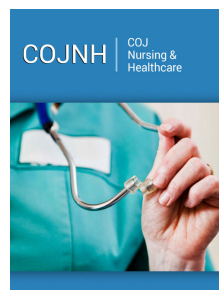
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