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Case Report

CASE OF PARAPHILIA WITH FOREIGN BODY IN DESCENDING COLON

***Katari Gopalakrishnan Vishnukumar, Vinoth, M., Gundaram Vikram Reddy, Thanzil Ahmed, I. and Muthukumaran, G.**

Saveetha Medical College, Chennai, Tamilnadu, India

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Abstract

A 28-year-old male with no known co-morbidities or illness came to the emergency department with a foreign body inserted in the rectum for the pleasure of autoeroticism. On examination of the abdomen foreign body was felt at the left hypochondrium. A digital rectal examination was done foreign body was not palpable, clinical features were suggestive of retained foreign body in the large intestine. X-ray abdomen showed - Shadow within the shadow in the region of the large bowel. Retrieval of the foreign body could be laparoscopy or laparotomy or colonoscopy. Colonoscopy was done and identified the foreign body in descending colonnear the splenic flexure. Colonoscopic retrieval of foreign body was attempted, but could not be retrieved because of the colon's large size and thinned-out mucosa. Hence planned exploratory laparotomy was done and the foreign body was present, in the descending Colon. The foreign body was milked from above through the pelvic floorand it was removed from the anal canal. Removing foreign bodies has evolved with technological advancements, with laparoscopy, endoscopy, and minimally invasive surgical alternatives. In this article, we have presented a unique case of foreign body removal through laparotomy.

Keywords: Paraphilia, Laparotomy.

INTRODUCTION

Even though foreign bodies in the rectum (RFB) are present occasionally in the emergency department these are not new to medical literature. Rectal foreign bodies (RFBs)were first reported dating back to the 16 century (Kurer *et al., 2010*). The act of inserting a foreign body into an orifice is known as polyembolokoilamania when motivated by sexual desire and is considered to be paraphilia. Which is increasing in population (Goldberg and Steele, 2010). The average age of presentation is 44 years, and commonly seen inmen (Goldberg and Steele, 2010). Even though there are many objects inserted in the rectum, the most common among them are glass bottles (Cologne and Ault, 2012). Some of the reasons for rectal foreign body insertion include sexual gratification, concealment, as may be the case in body packers, sexual assault, and, rarely, accidental causes, but the most common purpose is autoeroticism due to the increasing use of a foreign body for anal sex (Clarke *et al.,* 2005; Caliskan *et al.,* 2011). The patient might present to the emergency immediately because he is not able to remove the foreign body. Sometimes the time of presentation varies from the time of insertion. At times it might take up to two weeks before the presentation due to embarrassment. Even on arrival, such patients often try to conceal the true nature of their presentation to the emergency department (Lake *et al.,* 2004). In this article, we have presented a case of a 28-year-old patient who came to the emergency with a foreign body in the rectum, for the pleasure of autoeroticism which was confirmed by X-ray, and colonoscopic retrieval was tried which was failed. Hence patient was planned for laparotomy and the foreign body was removed through the anal canal.

Corresponding Author:** ***Katari Gopalakrishnan Vishnukumar,
Saveetha Medical College, Chennai, Tamilnadu, India.

CASE REPORT

A 28-year-old male came to the emergency department with an alleged history of foreign body insertion per rectum after one day, complaints of pain in the anal region, and foreign body sensation in the left lower abdomen, he had no history of abdominal pain, vomiting, trauma, passed stools in morning &patient had a similar history in the past which was easily removed by the patient manually per annum on and off for 2 years. The patient's vitals were stable. On examination of the abdomen was soft, with no abdominal distention, Mild tenderness present over the lower abdomen, mass palpable over the left hypochondrium and lumbar region, no free fluid present, no organomegaly, no guarding, no rigidity, bowel sounds sluggish, digital rectal examination showed - dilated sphincter, soft stools +, no mass/foreign body palpable. Provisional Diagnosis of retained foreign body in the large intestine. Blood investigations were found to be normal. X-ray Abdomen showed - Shadow within the shadow in the region of descending colon of the large bowel [Fig 1]. Colonoscopy was done and identified the foreign body in descending colon near the splenic flexure colonic mucosa was found to be thinned out Colonoscopic retrieval of the foreign body was attempted, but the procedure failed due to the large size and thinned out mucosa of the colon [Fig 2]. Hence planned for exploratory laparotomy. The patient underwent an exploratory laparotomy. Since the colonic mucosa was thinned out laparoscopic method was deferred. Under anesthesia digital rectal examination was done foreign body was not palpable. Per abdomen examination, a foreign body was felt at the left hypochondrium. Intraoperatively Foreign body was palpable in the descending colon, other organs were found to be normal. A thorough laparotomy was done. The foreign body was milked from above and brought up to the Pelvic floor and fixed by another surgeon. Then foreign body (Plastic bottle) is removed rectally which is measured (14 * 6* 3cms) [Fig 3, 4]. The Post-

op period was uneventful. The patient was discharged on POD#7.

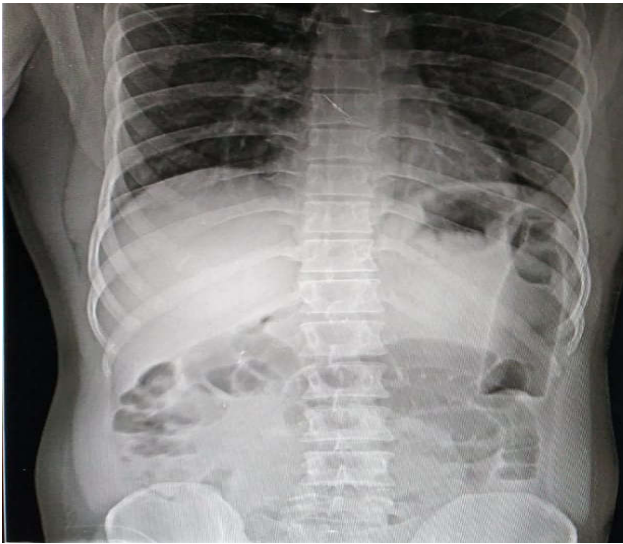

Fig. 1. Shadow within the shadow in the region of the large bowel (Foreign Body)

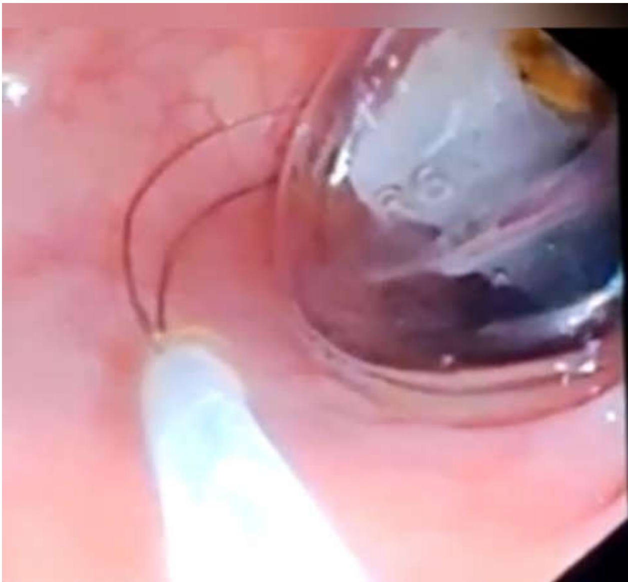

Fig. 2. Foreign body in descending colon near the splenic flexure

Fig. 3. Foreign body being removed Per rectally

Fig. 4. Foreign body (size- 14cms) after removing from the rectum

Table 1.

Grade	Type of injury	Description
I	Hematoma	Contusion or hematoma without devascularization
II	Laceration	Partial-thickness laceration
III	Laceration	Laceration < 50% of circumference
IV	Laceration	Laceration >= 50% of circumference
V	Vascular injury	Devascularized segment

DISCUSSION

Rectal foreign bodies either due to accidental insertion or from other causes, which are presenting to the emergency department often pose a challenging diagnostic and management dilemma that begins with the initial evaluation within the emergency department and continues through the post-extraction period. Some of the objects from billy clubs, varied fruits, and vegetables, and light bulbs are described as retained rectal foreign bodies. Variable trauma may be caused to local tissue of the rectum and distal colon hence a scientific approach to diagnosis and management is needed. Most patients are embarrassed and reluctant to get medical aid, which delays the presentation time and results in complications such as acute obstruction perforation, Bowel ulceration, bowel laceration, bleeding, peritonitis, infection, and even sepsis making the management still more difficult. Sometimes patients are often but truthful regarding the explanation for their visit, resulting in extensive workups and further delays. Even after extraction, rectal foreign bodies can cause significant bleeding or result in perforation. The patient needs, a stepwise approach to the diagnosis, removal, and post-extraction evaluation is crucial (Lake *et al.,* 2004). Involuntary sexual foreign bodies are almost exclusively within the domain of rape and sexual abuse. Body packing is often utilized by drug traffickers who insert or swallow through the oral or rectal route. Sometimes several packages of medicine (usually heroin or cocaine) wrapped in plastic bags or condoms are swallowed. Complications resulting from body packing include impaction, obstruction, perforation, and even rupture of the bowel. Rectal foreign bodies present a difficult diagnostic and management dilemma, due to delayed presentation, big variety of objects that cause the damage, wide spectrum of injury patterns which are minimal extraperitoneal mucosal injury to free intraperitoneal perforation, sepsis, and even death. In traumatic rectal injuries, Rectal Organ Injury Scale (ROIS) was used to classify. Rectal lesions were classified as Grade I (simple contusion) to Grade V (devascularization of rectal segment) [Table 1] through appropriate radiographic examination (Yildiz *et al.,* 2013). The

patient needs to be resuscitated with intravenous fluids and antibiotics if needed. Radiologic evaluation is way more important than any laboratory test. A flat and upright series of the x-ray abdomen will show the placement of the foreign body and therefore the presence or absence of pneumoperitoneum. Caudal or anal block and intravenous sedation are essential for adequate anal dilatation which helps in successful transanal extraction. Other features such as sphincter function, tone and contractility, and continence should be evaluated. By giving bimanual pressure on the anterior abdominal wall, the foreign body can be grasped with forceps, manipulated with a foley catheter, and magnets for metal objects (Yildiz *et al.,* 2013). Rectosigmoidoscopy for transanal removal of rectal foreign body avoids surgery (Kantarian *et al.,* 1987). Surgical procedures either laparotomy/laparoscopy must be reserved for patients with perforation or ischemic bowel or cases of failed trans anal attempts Moree *et al,* have described that treatment of all rectal injuries depends on the degree of injury, with or without hematoma, and the presence of circumference laceration, and whether there is devascularization of the rectum and perforation/extension into the perineum (Moore *et al.,* 1990). If the patient is stable article can be removed with appropriate anesthesia via the transanal approach. When this fails, then the patient must be taken to the operating theatre for a deeper anesthetic and attempt at trans anal extraction. Surgical procedures either laparotomy/laparoscopy must be reserved for patients with perforation or ischemic bowel or cases of failed trans anal attempts. Colostomy is not mandatory in these patients. But sometimes it all depends on overall condition, length of time in case of perforation, comorbidities, concomitant injuries, and surgical judgment. Moore et al, have explained the need, for rigid or flexible endoscopy after a period of observation to judge for rectal injury, and repeat plain films to look for evidence of injury and perforation which will have occurred during the extraction process (Lake *et al.,* 2004).

Conclusion

Rectal foreign bodies are a common entity. Most of them were removed through colonoscopy/laparoscopy. This is a unique case of a large foreign body in descending colon with thinned out mucosa of the colon for which laparotomy is required for removal to prevent perforation.

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