Rectal Foreign Body: The not so good, the bad and the ugly

David E. Rivadeneira, M.D., FACS, FASCRS
Colon & Rectal Surgery
St. Catherine of Siena Medical Center
Smithtown, NY

Disclosures

- Applied Medical: Honorarium/speaker
- Covidien: Honorarium/speaker
- Trans 1: Honorarium/speaker
Disclosures

- I did NOT come up with the title of this talk “Rectal Foreign Body: The not so good, the bad and the ugly”
- The title was given to me by Dr. Maher Abbas
- I have never had so much fun putting a talk together
- In my humble opinion there is Never a good rectal foreign body, unless...

Rivadeneira's hybrid-methane motorcycle
Sit back and enjoy the talk

Have a coke and a smile

Approach to the rectal foreign body

- Never underestimate what some people will put in their own or their partners rectum
  - The actual object
  - Size
  - Quantity
Coffee jar

Provided by Dr. Maher Abbas
Evaluation

- First step is always be aware of the possibility of a large bowel perforation and perform radiological investigations.
- Plain abdominal radiography or water soluble contrast enemas may be helpful.
- Localization of the foreign body, whether it is below or above the rectosigmoid junction.

Approach to the rectal foreign body

- First, digital removal of the object should be attempted.
- If fails, one can try bimanual manipulation, may need anesthesia.
- Next step will depend on the location, size, material or consistency of the foreign body.
Approach to the rectal foreign body

- Insertion of an endoscope with subsequent attempts to grasp the foreign body with regular endoscopy accessories like polypectomy snares.
- When this fails, it may be helpful to use devices that can be inflated in the rectosigmoid, such as a Foley catheter or an achalasia balloon.
- Such a device prevents a vacuum that might develop upon extraction of the foreign body and may also be directly used to remove the object.
If these interventions fail, then full relaxation of the anal sphincter muscles can be achieved by local, spinal or general anesthesia.

Bimanual manipulation of the relaxed abdominal wall under spinal or general anesthesia may evade surgery.

When conservative measures fail, laparoscopic or open approaches are indicated.

After removal, sigmoidoscopy is generally recommended to rule out perforations.
Use of bimanual

Letters to the Editor

Impaction of a Bacterial Foreign Body: What is the Final Approach Before Surgery?
In the May 2006 issue of Diseases of the Colon & Rectum, we described a case of a 12-year-old boy with acute abdominal pain. The patient had a history of appendectomy and had recovered uneventfully. He presented with acute colonic obstruction and was found to have an impacted foreign body in the transverse colon. A transanal approach was attempted, but due to the size of the foreign body, a transrectal approach was necessary. The foreign body was successfully removed, and the patient recovered uneventfully. This case highlights the importance of a multidisciplinary approach in the management of impactions and foreign bodies in the colon and rectum.

Figure 1: Transanal approach demonstrated a tight fit of the object.

Figure 2: The foreign body was successfully removed.

Management of retained colorectal foreign bodies: predictors of operative intervention

- Largest series, 93 cases with transanal introduction
- Bedside extraction was successful in 74%
- 23 patients were taken to the operating room
- 17 examinations under anesthesia and 8 laparotomies were performed
- Eight patients who underwent exploratory laparotomy, only one had successful delivery of the foreign object into the rectum for transanal extraction
- Remainder required repair of perforated bowel or retrieval of the foreign body via a colotomy

Lake et al DCR 2006
Management of retained colorectal foreign bodies: predictors of operative intervention

- Fifty-five percent of patients (6/11) presenting with a foreign body in the sigmoid colon required operative intervention vs. 24 percent of patients (17/70) with objects in their rectum (P = 0.04).

Lake et al DCR 2006

Management of retained colorectal foreign bodies: predictors of operative intervention

- Largest series of patients with rectal foreign bodies described thus far (n = 93), it was found that objects retained for more than 2 days, those larger than 10 cm and those located proximal to the rectum increase the likelihood of surgery.
A Simple Technique for Removing an Impacted Aerosol-can Cap from the Rectum

Marcelo M. Aguiar, M.D., B.S., Janice M. Tuazon, M.D.

Use of vaginal speculums

Use of an esophageal dilation balloon
Bottle cork opener

A little riuniti on ice, is so nice!