

Images in...

Pandora's box: a threatening foreign body

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DESCRIPTION

A 38-year-old man, a prisoner at a district jail, was brought to the accident and emergency department complaining of gastric pain accompanied by nausea but without vomiting. He had no fever and his vital parameters were normal.

Blood testing, including full blood count, C reactive protein, liver function tests and cardiac enzymes were unremarkable. Examination revealed a firm mass, palpable at the level of the mesogastrium in an otherwise soft and non-tender abdomen. The patient related passing no flatus or stools in the previous 24 h.

On rectal examination, a solid foreign body was felt. Pushing that body transmitted an impulse palpable in the mesogastrium. At this point, the patient revealed to have privately inserted a foreign body into the rectum few hours earlier.

This prompted an immediate CT scan of the abdomen. The whole sigmoid colon, from the rectum up to the descending colon, was stretched by a peppermill-shaped object. Neither intra-abdominal free air nor free fluid was present (figures 1–3).

The patient was taken to the theatre and under general anaesthesia, the foreign body (figure 4) was manually extracted, avoiding a midnight laparotomy. A psychiatric and psychosocial assessment was provided, following the patient's request, the next day.

'Self-injurious' behaviour is a fairly common phenomenon in prisoners, but most reports are found in the surgical and gastroenterological literature. They tend to focus on complication rates and surgical techniques for removing the object. More prospective studies of the subset of individuals who exhibit self-injurious behaviour will help



Figure 1 Plain abdominal x-ray showing the rectal body. The size of the foreign body seems small and the object seems sharp.

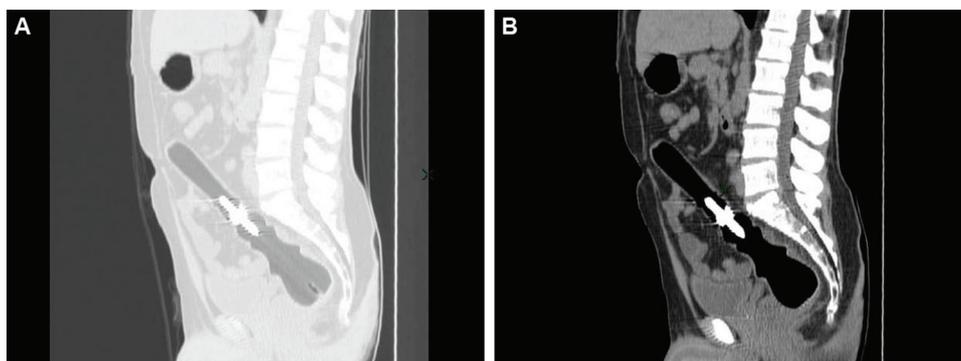


Figure 2 Multiplanar-reformation CT scan demonstrating the real size (over 20 cm in length) of the rectal foreign body, extending upwards and reaching the mesogastrium and left hypochondrium.

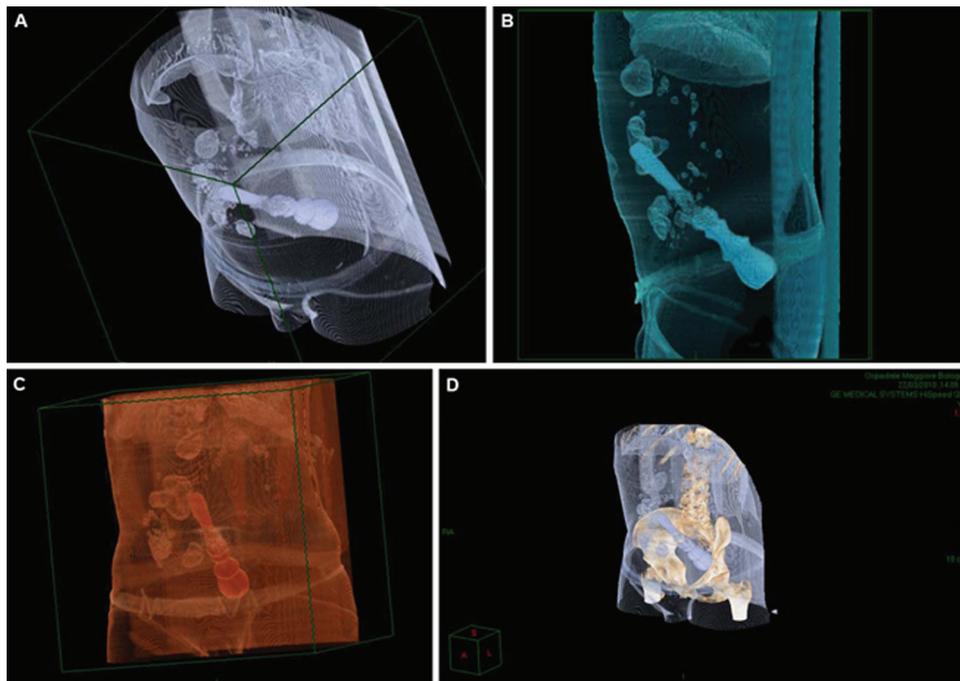


Figure 3 Three-dimensional reconstruction CT scan showing the actual size, location, direction and extent of the foreign body inside the abdominal cavity as well as the relationship with surrounding structures.



Figure 4 Foreign body.

in the development of appropriate treatment and management approaches.¹

The emergency room physician must confirm the presence of rectal foreign body. Extraction in an emergency room setting is usually impossible and patients with persistent rectal foreign bodies should be referred to a colorectal surgeon.² Rectal foreign bodies are amenable to transanal extraction. Those located in the sigmoid colon more often require repair of perforated bowel or retrieval via a colotomy.³

Competing interests None.

Patient consent Obtained.

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