Case report

A 51-year-old man presented with a retained colorectal foreign body that was introduced transanally for sexual stimulation. According to the patient, it was a 15-cm long plastic tube. On physical examination, a tubular-shaped mass could be palpated in the patient’s lower abdomen. No foreign body was detected on rectal examination. Initial examination of the abdominal plain film (Fig. 1) revealed only a dilated loop of bowel in the lower portion of the abdomen. However, detailed examination revealed a shadow whose location corresponded to the clinically palpable mass and that was actually the foreign body. Colonoscopy under mild sedation identified the lower end of the foreign body positioned 18 cm from the anal verge. However, the endoscopist failed to retrieve the foreign body by forceps, basket, balloon or snare. Eventually, the patient was given a general anesthetic. A pair of toothed laparoscopic forceps was inserted per anus under colonoscopic guidance, and the foreign body was securely grasped and removed. It was a tubular sponge, 15 cm long and 3 cm in diameter (Fig. 2). The material was radiolucent, but the air trapped inside it had given an interesting and characteristic appearance on the plain radiograph.

Discussion

More proximally located foreign bodies can occasionally be palpated on abdominal examination, as in this case. Plain radiography is useless for visualizing...
radiolucent foreign bodies; however, it is interesting that the air trapped in the sponge in this case created a column of air mimicking a loop of dilated bowel. Transanal retrieval is usually successful, either under conscious sedation or general anesthesia. In difficult cases, a combined laparoscopic and endoanal approach has been used, in which the foreign body is pushed down to the rectum laparoscopically and then retrieved transanally. When colorectal perforation exists, or for foreign bodies that resist retrieval by other means, laparotomy is required.

Competing interests: None declared.

References