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### RESEARCH ARTICLE

#### LARGE COLORECTAL FOREIGN BODY VOLUNTARILY INTRODUCED: A CASE REPORT

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#### Abstract

Intra-rectal foreign bodies (IRFBs) are a rare but increasingly recognized condition, often associated with voluntary insertion. We report the case of a 30-year-old man who presented with an incarcerated rectal foreign body—a mortadella sausage—inserted three days before admission. Imaging did not visualize the object, necessitating transanal extraction under sedation. The postoperative recovery was uneventful, with normal bowel function returning the same day. The management of IRFBs requires a multidisciplinary approach to minimize complications. Early diagnosis, appropriate imaging, and a non-judgmental approach are essential for successful outcomes and prevention of recurrence

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#### Introduction:

In this report, we present the case of a patient who experienced the incarceration of an unusually large object voluntarily introduced into the anal canal. This case highlights the diagnostic challenges, therapeutic strategies, and potential complications associated with this rare but increasingly recognized condition.

When the foreign body is small, it may pass spontaneously or be easily extracted. However, large objects pose a significant diagnostic and therapeutic challenge due to the risk of rectal perforation, obstruction, or severe mucosal injury. Managing such cases requires a multidisciplinary approach, involving gastroenterologists, radiologists, and surgeons, to determine the most appropriate and least invasive extraction technique. [1-2].

In this report, we present the case of a patient who experienced the incarceration of an unusually large object voluntarily introduced through the anal canal. This case highlights the diagnostic challenges, therapeutic strategies, and potential complications associated with this rare but increasingly recognized condition.

#### Patient and Case Report:

This case involves a 30-year-old male patient admitted to the emergency department for the management of an incarcerated intra-rectal foreign body (FB). Upon arrival, he had no significant medical history. According to his account, the incident occurred three days before admission when he voluntarily inserted a mortadella sausage into his rectum.

Clinically, the abdominal examination was unremarkable, with a soft abdomen and mild hypogastric tenderness. Bowel sounds were present. Notably, the patient refused a digital rectal examination during his emergency department visit.

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A plain abdominal X-ray did not reveal the foreign body, as it was not radio-opaque. Consequently, transanalextraction was performed under sedation in the operating room, with the patient in the dorsal decubitus position.

Following the extraction, the patient was placed under observation. The postoperative course was uneventful, with the return of bowel function, including the passage of gas and stool, on the same day as the procedure. The patient was subsequently discharged without complications

**Discussion:**

Intra-rectal foreign bodies (IRFBs) represent a rare but increasingly recognized clinical entity, often associated with voluntary insertion for autoerotic purposes, psychiatric conditions, or criminal intent. Although the actual prevalence is difficult to determine due to underreporting, the number of documented cases has been rising globally, particularly in urban settings [1].

The management of IRFBs is challenging due to several factors, including delayed presentation, patient reluctance to disclose the incident, and the risk of complications such as perforation, obstruction, or infection. In this case, the patient delayed seeking medical attention for three days, increasing the risk of mucosal damage and secondary complications. The refusal of a digital rectal examination further complicated the initial assessment, emphasizing the importance of a non-judgmental approach to encourage full cooperation.

Imaging plays a crucial role in diagnosing IRFBs, especially when the object is not radio-opaque, as seen in this case. Plain X-rays are typically the first-line investigation to determine the object's presence, size, and location while ruling out complications such as pneumoperitoneum (a sign of perforation). However, if the foreign body is not visible on X-ray, CT scanning may be necessary for better visualization and to assess any associated injuries

The primary goal in managing IRFBs is safe and minimally invasive extraction while avoiding iatrogenic injuries. Treatment approaches depend on factors such as size, shape, texture, and location of the object, as well as the presence of complications [3].

Small, distally located foreign bodies can often be removed manually in the emergency room under sedation or regional anesthesia. In cooperative patients, techniques such as the vacuum effect, use of endoscopic forceps, or obstetric suction devices may facilitate removal [7].

When conservative attempts fail, as in this case, extraction under general anesthesia in an operating room setting becomes necessary [6]. This approach allows for better patient relaxation, reducing the risk of trauma during manipulation. In certain cases, particularly for large or proximally migrated objects, laparotomy or laparoscopic-assisted extraction may be required, though this is reserved for cases with suspected perforation or peritonitis [5].

Post-extraction observation is essential to monitor for delayed complications, such as perforation, peritonitis, or sepsis. In this case, the patient recovered uneventfully, with the return of normal bowel function on the same day, supporting a good prognosis [4].

Additionally, psychiatric evaluation or psychological counseling may be beneficial in cases involving recurrent self-insertion or underlying psychiatric disorders. While many patients do not require psychiatric intervention, education on potential complications and preventive strategies should be provided to reduce recurrence. [1].

**Conclusion:**

This case illustrates the diagnostic and therapeutic challenges associated with large intra-rectal foreign bodies. A systematic approach, including detailed history-taking, appropriate imaging, and a stepwise extraction strategy, is essential for successful management. Early intervention, a multidisciplinary approach, and a non-judgmental patient-centered strategy are key to improving outcomes and preventing future occurrences.



Figure 1:- ASP avant extraction du Corps étranger.



Figure 2:- Image du corps étranger en endoscopie.



**Figure 3:-** Extraction réussie à l'anse.

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