Rectal foreign bodies: a single-centre 20-year retrospective

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AIMS

To evaluate the clinical characteristics and treatment of patients presenting to St Vincent's Public Hospital with rectal foreign body (RFB) over the past 20 years. Specifically, we want to see if any risk factors predispose patients to laparotomy for foreign body removal, examine patient outcomes after foreign body removal, and evaluate whether the rate of RFB presentation has increased since the COVID-19 pandemic (from March 2020). We hope to add to the current existing guidelines, which will potentially improve outcomes for patients presenting in the future.

DESIGN

A retrospective review over 20 years (01/10/2001 – 01/10/2021) of RFB presentations to St Vincent's Public Hospital.

METHODS

We will be performing a retrospective review of all patients presenting to St Vincent's Public Hospital, Sydney with a RFB from October 2001 to October 2021. We will collect data from admission notes and imaging reports, and may need to consult operation reports and discharge summaries to clarify information, complemented by a review of individual electronic and written medical records when required. Type of foreign body, method of removal, need for laparotomy, and other data will be collected.

LITERATURE REVIEW

The historical incidence of RFB is low and difficult to calculate, however recent estimates are as high as one per month in a tertiary trauma centre [1]. A review of 109 patients showed the most commonly retained objects were household items (42.2%), 'other' objects including rocks and sticks (16%), with sexual objects accounting for 15% of presentations [2]. Three types of removal techniques have been described: transanal, endoscopic, or surgical. Transanal techniques involve direct removal via the anal canal. Endoscopic removal involves using a flexible sigmoidoscope to image the foreign body, then using either scope adjuncts (e.g. snare or suction) or manual instruments under vision to retrieve the RFB and remove it transanally. Laparotomy is indicated when transanal or endoscopic attempts have failed. After midline laparotomy, the FB can be massaged back down to the rectum and retrieved transanally by the operator [3]. Colotomy or resection is usually reserved for extreme cases where the foreign body is unable to be removed or there is an impending risk of perforation.

References:

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