

World Journal of *Clinical Cases*

World J Clin Cases 2024 April 16; 12(11): 1857-1999



Contents

Thrice Monthly Volume 12 Number 11 April 16, 2024

EDITORIAL

- 1857 Primary pulmonary meningioma and minute pulmonary meningotheial-like nodules: Rare pulmonary nodular lesions requiring more awareness in clinical practice
Liu LD, Zhang KX, Zhang HN, Zheng YW, Xu HT
- 1863 Advances in clinical applications of bioceramics in the new regenerative medicine era
Elshazly N, Nasr FE, Hamdy A, Saied S, Elshazly M
- 1870 Climate change and human health: Last call to arms for us
Corrente A, Pace MC, Fiore M
- 1875 Protocol for lower back pain management: Insights from the French healthcare system
Boyer LE, Boudier-Rev  ret M, Chang MC
- 1881 Removal of intrahepatic bile duct stone could reduce the risk of cholangiocarcinoma
Jagirdhar GSK, Bains Y, Surani S

REVIEW

- 1885 Unexpected focal fluorodeoxyglucose uptake in main organs; pass through or pass by?
Lee H, Hwang KH

MINIREVIEWS

- 1900 Research progress on venous thrombosis development in patients with malignant tumors
Wang TF, Chen Q, Deng J, Li SL, Xu Y, Ma SX
- 1909 Splenic hamartomas in children
Milickovic M, Rasic P, Cvejic S, Bozic D, Savic D, Mijovic T, Cvetinovic S, Djuricic SM

ORIGINAL ARTICLE

Retrospective Study

- 1918 Chaiqin Chengqi Decoction as an adjuvant treatment for mild/moderately severe hypertriglyceridemic acute pancreatitis: A retrospective study
Zhang HF, Su ZX, Feng YH, Li SJ, Xie BY

Observational Study

- 1929 COVID-19 pandemic amplified mortality rates among adolescents with bipolar disorder through family-related factors
Ye ZF, Hong YH, Yang JL, Tan MQ, Xie JM, Xu ZC

CASE REPORT

- 1936** Tricuspid mass-curious case of Li-Fraumeni syndrome: A case report
Huffaker T, Pak S, Asif A, Otchere P
- 1940** Endovascular treatment of direct carotid cavernous fistula resulting from rupture of intracavernous carotid aneurysm: A case report
Ouyang G, Zheng KL, Luo K, Qiao M, Zhu Y, Pan DR
- 1947** Concomitant treatment of ureteral calculi and ipsilateral pelvic sciatic nerve schwannoma with transperitoneal laparoscopic approach: A case report
Xiong Y, Li J, Yang HJ
- 1954** Safety and efficacy of transcatheter arterial embolization in autosomal dominant polycystic kidney patients with gross hematuria: Six case reports
Sui WF, Duan YX, Li JY, Shao WB, Fu JH
- 1960** Neurosyphilis complicated by anti- γ -aminobutyric acid-B receptor encephalitis: A case report
Fang YX, Zhou XM, Zheng D, Liu GH, Gao PB, Huang XZ, Chen ZC, Zhang H, Chen L, Hu YF
- 1967** Long-term complete response to anti-programmed-death-1 monotherapy in a patient with relapsed and refractory ovarian adenocarcinoma: A case report
Zhou GD, Li Q
- 1974** Nd:YAG water mist laser treatment for giant gestational gingival tumor: A case report
Chen HY, Xu JJ, Chang XL, Wu P
- 1980** Hematochezia due to rectal invasion by an internal iliac artery aneurysm: A case report
Li F, Zhao B, Liu YQ, Chen GQ, Qu RF, Xu C, Long Z, Wu JS, Xiong M, Liu WH, Zhu L, Feng XL, Zhang L
- 1990** Colonoscopy-assisted removal of an impaction foreign body at the rectosigmoid junction: A case report
Zhou PF, Lu JG, Zhang JD, Wang JW

LETTER TO THE EDITOR

- 1996** Intestinal flora: New perspective of type 2 diabetes
Liu Y, Chang J, Bai LD

ABOUT COVER

Peer Reviewer of *World Journal of Clinical Cases*, Gennaro Mazzaella, MD, Surgeon, Department of Surgery "Pietro Valdoni", Sapienza University of Rome, Rome 00161, Italy. gennaromazzaella226@gmail.com

AIMS AND SCOPE

The primary aim of *World Journal of Clinical Cases* (WJCC, *World J Clin Cases*) is to provide scholars and readers from various fields of clinical medicine with a platform to publish high-quality clinical research articles and communicate their research findings online.

WJCC mainly publishes articles reporting research results and findings obtained in the field of clinical medicine and covering a wide range of topics, including case control studies, retrospective cohort studies, retrospective studies, clinical trials studies, observational studies, prospective studies, randomized controlled trials, randomized clinical trials, systematic reviews, meta-analysis, and case reports.

INDEXING/ABSTRACTING

The WJCC is now abstracted and indexed in Science Citation Index Expanded (SCIE, also known as SciSearch®), Journal Citation Reports/Science Edition, Current Contents®/Clinical Medicine, PubMed, PubMed Central, Reference Citation Analysis, China Science and Technology Journal Database, and Superstar Journals Database. The 2023 Edition of Journal Citation Reports® cites the 2022 impact factor (IF) for WJCC as 1.1; IF without journal self cites: 1.1; 5-year IF: 1.3; Journal Citation Indicator: 0.26; Ranking: 133 among 167 journals in medicine, general and internal; and Quartile category: Q4.

RESPONSIBLE EDITORS FOR THIS ISSUE

Production Editor: Zi-Hang Xu, Production Department Director: Xiang Li, Cover Editor: Jin-Lai Wang.

NAME OF JOURNAL

World Journal of Clinical Cases

ISSN

ISSN 2307-8960 (online)

LAUNCH DATE

April 16, 2013

FREQUENCY

Thrice Monthly

EDITORS-IN-CHIEF

Bao-Gan Peng, Salim Surani, Jerzy Tadeusz Chudek, George Kontogeorgos, Maurizio Serati

EDITORIAL BOARD MEMBERS

<https://www.wjgnet.com/2307-8960/editorialboard.htm>

PUBLICATION DATE

April 16, 2024

COPYRIGHT

© 2024 Baishideng Publishing Group Inc

INSTRUCTIONS TO AUTHORS

<https://www.wjgnet.com/bpg/gerinfo/204>

GUIDELINES FOR ETHICS DOCUMENTS

<https://www.wjgnet.com/bpg/GerInfo/287>

GUIDELINES FOR NON-NATIVE SPEAKERS OF ENGLISH

<https://www.wjgnet.com/bpg/gerinfo/240>

PUBLICATION ETHICS

<https://www.wjgnet.com/bpg/GerInfo/288>

PUBLICATION MISCONDUCT

<https://www.wjgnet.com/bpg/gerinfo/208>

ARTICLE PROCESSING CHARGE

<https://www.wjgnet.com/bpg/gerinfo/242>

STEPS FOR SUBMITTING MANUSCRIPTS

<https://www.wjgnet.com/bpg/GerInfo/239>

ONLINE SUBMISSION

<https://www.f6publishing.com>



Colonoscopy-assisted removal of an impaction foreign body at the rectosigmoid junction: A case report

Peng-Fei Zhou, Jin-Gen Lu, Jia-Dong Zhang, Jia-Wen Wang

Specialty type: Medicine, research and experimental

Provenance and peer review: Unsolicited article; Externally peer reviewed.

Peer-review model: Single blind

Peer-review report's scientific quality classification

Grade A (Excellent): 0
Grade B (Very good): B
Grade C (Good): 0
Grade D (Fair): 0
Grade E (Poor): 0

P-Reviewer: Grawish ME, Egypt

Received: January 25, 2024

Peer-review started: January 25, 2024

First decision: February 2, 2024

Revised: February 7, 2024

Accepted: March 15, 2024

Article in press: March 15, 2024

Published online: April 16, 2024



Peng-Fei Zhou, Jin-Gen Lu, Jia-Dong Zhang, Jia-Wen Wang, Department of Anorectal Surgery, Longhua Hospital Shanghai University of Traditional Chinese Medicine, Shanghai 200000, China

Corresponding author: Jia-Wen Wang, MD, Doctor, Department of Anorectal Surgery, Longhua Hospital Shanghai University of Traditional Chinese Medicine, No. 725 Wanping South Road, Xuhui District, Shanghai 200000, China. drwangjiawen@163.com

Abstract

BACKGROUND

When an anorectal foreign body is found, its composition and shape should be evaluated, and a timely and effective treatment plan should be developed based on the patient's symptoms to avoid serious complications such as intestinal perforation caused by displacement of the foreign body.

CASE SUMMARY

A 54-year-old male was admitted to our outpatient clinic on June 3, 2023, due to a rectal foreign body that had been embedded for more than 24 h. The patient reported using a glass electrode tube to assist in the recovery of prolapsed hemorrhoids, however, the electrode tube was inadvertently inserted into the anus and could not be removed by the patient. During hospitalization, the patient underwent surgery, and the foreign body was dragged into the rectum with the aid of colonoscopy. The anus was dilated with a comb-type pulling hook and an anal fistula pulling hook to widen the anus and remove the foreign body, and the local anal symptoms were then relieved with topical drugs. The patient was allowed to eat and drink, and an entire abdominal Computed tomography (CT) and colonoscopy were reviewed 3 d after surgery. CT revealed no foreign body residue and colonoscopy showed no metal or other residues in the colon and rectum, and no apparent intestinal tract damage.

CONCLUSION

The timeliness and rationality of the surgical and therapeutic options for this patient were based on a literature review of the clinical signs and conceivable conditions in such cases. The type, material and the potential risks of rectal foreign bodies should be considered.

Key Words: Foreign body impaction; Surgical therapy; Rectum-sigmoid colon; Colonoscopy; Case report

Core Tip: There are various reasons for the embedding of rectal foreign bodies. Depending on the type and shape of the embedded foreign body, timely and appropriate therapeutic measures to avoid intestinal damage caused by the foreign body are the key to effective treatment. We report the case of a patient with an impacted rectal foreign body for more than 24 h. As the embedded foreign body in this patient was a glass tube with metal needles at the end, removal of the foreign body was carried out in conjunction with gastrointestinal endoscopy.

Citation: Zhou PF, Lu JG, Zhang JD, Wang JW. Colonoscopy-assisted removal of an impaction foreign body at the rectosigmoid junction: A case report. *World J Clin Cases* 2024; 12(11): 1990-1995

URL: <https://www.wjgnet.com/2307-8960/full/v12/i11/1990.htm>

DOI: <https://dx.doi.org/10.12998/wjcc.v12.i11.1990>

INTRODUCTION

Depending on the entry route, foreign bodies can be classified as oral, anal, or endogenous in the gastrointestinal tract[1]. Localized injuries to the gastrointestinal tract caused by foreign bodies most frequently occur in the physiological corners or narrow portions of the gastrointestinal tract and are closely linked to the material, size and sharp edges of the foreign body. The two most prevalent areas are the ileocecal and sigmoid colon[2]. There are numerous sources of intestinal foreign bodies, including, but not limited to, masturbators, fruits, vegetables and glass. Various treatment approaches are required, depending on the composition of the foreign body. A foreign body consisting of soft material, smooth edges, and a small volume can be considered for removal through the anus; fruits and vegetables that are fragile may be extracted *via* the anus or following decomposition of a larger foreign body[3]. Due to the large size or fragility of glass products, such as wine bottles, these can easily cause damage to the intestinal wall, resulting in more serious complications. Therefore, multiple factors should be considered, including imaging examinations, to ensure patient safety[4].

CASE PRESENTATION

Chief complaints

A 54-year-old male was admitted to our hospital with the chief complaint of "rectal foreign body impaction for more than 24 h".

History of present illness

Rectal foreign body impaction for more than 24 h, was accompanied by difficulty in defecation, low stool volume, bloody stools, and a small amount of red blood discharged from the anus.

History of past illness

The patient reported that 24 h previously, due to prolapsed hemorrhoids (Figure 1A), he used an electrode tube for assisted reduction and inadvertently inserted the electrode tube into the anus, which could not be removed. He then used vascular forceps to clamp it, which could not be removed either. Moreover, according to the results of computed tomography (CT) in another hospital (not reported), the foreign body had reached the sigmoid colon, and the patient was unable to remove it following oral lactulose and enemas.

Personal and family history

The patient denied any family history of disease.

Physical examination

On physical examination, his vital signs were as follows: Temperature: 36.8 °C, pulse: 75 bpm, respiration: 15 breaths/min, blood pressure: 120/80 mmHg. The patient was conscious and cooperative. Pain associated with lower abdominal pressure, rebound pain, muscle tension, and mobile turbid sounds were negative.

Laboratory examinations

Laboratory tests on admission showed the following: White blood cells: $8.23 \times 10^9/L$, hemoglobin: 136 g/L, platelets: $207 \times 10^9/L$, and C-reactive protein: 26.71 ng/L.

Imaging examinations

A CT of the entire abdomen (Figure 1B) revealed an elliptical, cylindrical, metal-dense foreign body in the rectum

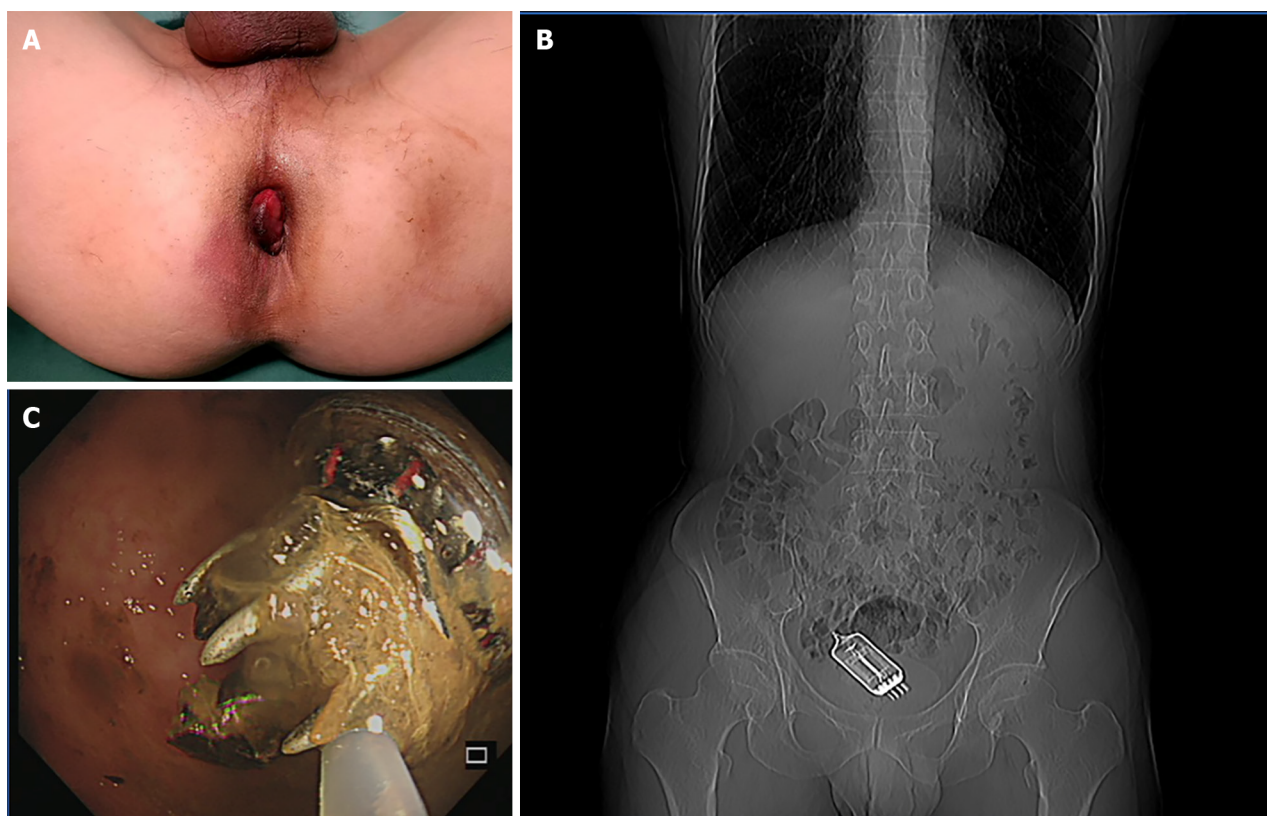


Figure 1 Computed tomography localization of the intestinal foreign body before surgery. A: The patient had anal opening edema, acute prolapsed internal anal hemorrhoids, and surface congestion and erosion prior to surgery; B: Preoperatively, the foreign body was located at the junction of the rectum and sigmoid colon by computed tomography scanning; C: During preoperative colonoscopy, a foreign body was found at the junction of the rectum and sigmoid colon, with the tail end wrapped in intestinal secretions.

measuring approximately 3 cm in diameter and 5.8 cm in length.

FINAL DIAGNOSIS

The final diagnosis in the patient was foreign body impaction at the rectosigmoid junction.

TREATMENT

Rectal foreign body removal was performed under subarachnoid block anesthesia in the operating room. After anesthesia induction, colonoscopy-assisted removal of the foreign body was attempted as finger examination and surgical instruments were unable to reach the foreign body, and gastrointestinal endoscopy revealed that the foreign body had shifted position and was located at the recto sigmoid junction (Figure 1C). The foreign body was characterized by a glass cylinder with metal spikes at the bottom (Figure 2A), and attempts to remove it using a foreign body net pocket during colonoscopy were unsuccessful. After using a ring lasso device and other aids, the foreign body was dragged to the anal canal. After expansion of the anus using comb-type hooks and anal fistula hooks, finger expansion was performed. Subsequently, curved vascular pliers were used to clamp the bottom of the foreign body, which contained metal needles, to facilitate removal of the object from the anus (Figure 2B).

OUTCOME AND FOLLOW-UP

The patient was allowed to eat and drink, and an entire abdominal CT (Figure 3A) and colonoscopy (Figure 3B) were reviewed 3 d after surgery. The CT revealed no foreign body residue, and colonoscopy showed no metal or other residues in the colon and rectum, and no apparent intestinal tract damage. 3 d after surgery, the symptoms of internal prolapsed hemorrhoids disappeared (Figure 3C). And this work has been reported in line with the Surgical case report criteria[5].

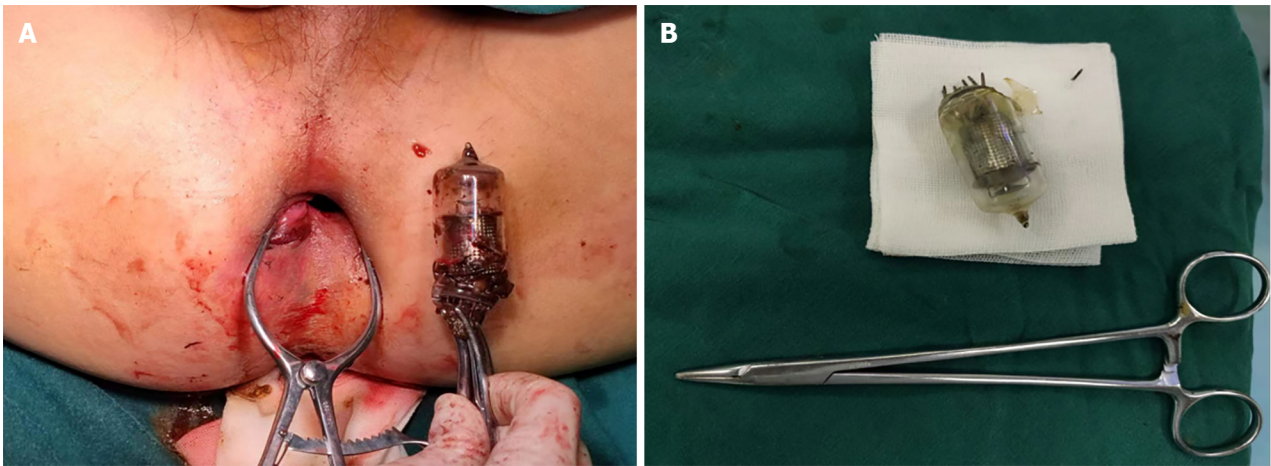


Figure 2 Postoperative foreign body morphology. A: The foreign body was tractioned to the anal opening with the aid of digestive endoscopy, and was then removed by manipulation with the aid of a comb-type pulling tool; B: Comparison of foreign object to a needle receptacle.

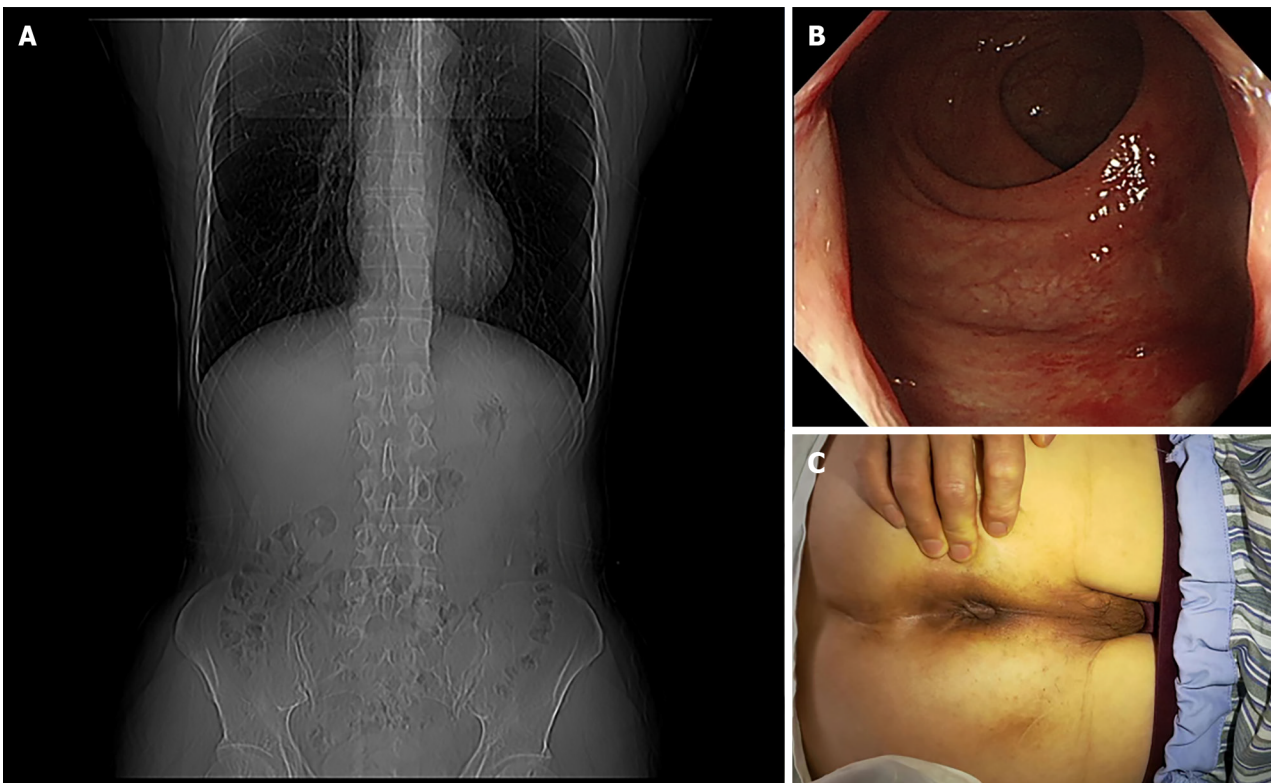


Figure 3 Postoperative evaluation of gastrointestinal foreign body and intestinal lumen status. A: After 3 d of postoperative follow-up, no foreign objects or residues were found on computed tomography scanning; B: 3 d later, a follow-up colonoscopy was performed, and there was no damage to the intestinal cavity and no foreign body residue; C: 3 d after surgery, the symptoms of internal prolapsed hemorrhoids disappeared.

DISCUSSION

The incidence of rectal foreign bodies is approximately 15 per 10000000 individuals[6]. Approximately 20% of rectal foreign bodies are initially masked by different complaints, such as pain, hemorrhage, or constipation, and are undetected until additional inquiries are made regarding the cause of the condition[7]. For example, in the case reported by Husain *et al*[8], the patient mainly presented with abdominal pain, and it was only discovered by chest CT that a perforation of the large intestine had been caused by a fishbone. Unlike Raja Husain's case where foreign bodies entered through the mouth, in this case, the foreign body entered through the anus, providing us with a basis for diagnosis and treatment. Rectal foreign bodies are an urgent and challenging issue for emergency physicians and anorectal surgeons. Patients may be admitted to the hospital and report abdominal discomfort to their attending physicians. Moreover, there is a tendency to conceal the cause of abdominal pain, and the presence of abdominal pain due to a rectal foreign body is given less consideration by physicians. Often, bowel function is preserved despite the patient's abdominal discomfort and inability

to defecate, which is one of the reasons why some physicians consider it an intestinal obstruction[8]. Rectal foreign bodies may be caused by sexual gratification, mental illness, physical assault, or surgical procedures[9]. The foreign body location is not limited to the rectum; however, in severe cases, it can result in tissue or organ injury, with complications including mucosal lacerations, foreign body migration to areas adjacent to the bowel, intestinal obstruction, perforation, peritonitis, and septicemia[10]. Yildiz *et al*[10] analyzed 30 patients with foreign bodies and found that 90% of patients complained of perianal pain, while 70% complained of abdominal pain. Consequently, the patient, in this instance, was hospitalized and fully informed of the patient's right to information prior to surgery, including the risks of the surgical process. The case reported by Simbila *et al*[11] was a male patient who inserted a lubricated plastic detergent bottle into the anus for sexual satisfaction, causing a 10 cm tear and perforation from the rectum to the sigmoid colon. Therefore, the patient underwent colostomy. In our case, during the treatment process, we adopted timely and effective treatment measures, which combined imaging, digestive endoscopy, and anorectal surgery, to select the most appropriate treatment and resolve the foreign body implantation issue.

Rectal foreign bodies and their effects on localized colorectal tissue necessitate systematic evaluation to develop treatment plans. In order to provide a more rational approach, the specific patient's condition in conjunction with a comprehensive physical and digital examination along with abdominal imaging, such as X-rays, and CT scans should be considered, to aid in the assessment and localization of the foreign body, as well as ancillary investigations to determine whether it is possible to attempt manual grasping of the object or endoscopic removal[12]. According to the literature [13], the success rate of removing foreign bodies at the bedside and in the emergency room is 16%-75%. Repeated attempts to remove foreign objects can lead to pain and severe involuntary intestinal spasms, which is one of the reasons for removal failure[14]. In this case, the patient used oral lactose and enemas, but failed to remove the foreign body, which resulted in its movement upward through the anus, and it eventually stopped at the junction of the rectum and sigmoid colon. If physical examination or imaging reveals peritonitis or perforation, surgical intervention should be considered immediately[15]. According to reports, 67% of rectal foreign body injuries do not penetrate the entire length of the rectal wall and thus do not necessitate surgical intervention. When the entire rectal wall is damaged, surgical intervention becomes more difficult, and peritoneal involvement may exacerbate the condition[16]. To minimize the complexity of removing a rectal foreign body, it is important to consider the shape, size, and composition of the object. Depending on the characteristics of the foreign body, methods such as sigmoidoscopy, endoscopy, or Foley catheters can be considered[17].

CONCLUSION

In this case, the embedded foreign body was composed of glass with spiny protrusions, and the location was too high for bedside removal. Therefore, the patient agreed to undergo colonoscopy. Simultaneously, due to the specificity of the embedded foreign body, for industrial diodes, glass products, first and foremost, have the risk of breaking, and once broken, will cause damage to the patient's intestinal lumen, not only increasing the difficulty of the operation but also placing the patient's life in jeopardy. In addition, due to the uncertainty of whether the diode's interior and exterior contain heavy metals and other uncertain materials, and whether it will cause toxicity, there is also a degree of surgical uncertainty; therefore, timely and effective removal of the foreign body is essential. The drawback in this case is that we did not have a more suitable tool to remove the foreign body, which caused damage to the glass when paired with a colonoscope hook. This poses a hidden danger in this type of surgery. However, subsequent observations revealed that this did not lead to other concurrent symptoms. Due to the timely management of this patient, the foreign body was successfully removed. Therefore, in the future, it is necessary to have a suitable surgical plan and surgical tool when dealing with similar clinical cases. The foreign body embedded in the rectum, in this case, was composed of glass, which is easily damaged. Consequently, violent removal should not be conducted during the surgical process to avoid glass breakage, which may injure the intestine.

ACKNOWLEDGEMENTS

We thank our colleagues for assistance in reviewing this manuscript. We would especially like to thank Dr. Shi Bei and his assistants at the Endoscopy Center for all their help.

FOOTNOTES

Author contributions: Zhou PF and Wang JW contributed to manuscript writing and editing, and data collection; Lu JG guided the treatment of this case; Zhang JD collected data of this case.

Supported by National Natural Science Foundation of China Project, No. 82004374; and The Second Round of Construction Project of National TCM Academic Schools Inheritance Workshop of the State Administration of Traditional Chinese Medicine, No. [2019]62.

Informed consent statement: Informed written consent was obtained from the patient for publication of this report and any accompanying images.

Conflict-of-interest statement: All the authors report no relevant conflicts of interest for this article.

CARE Checklist (2016) statement: The authors have read the CARE Checklist (2016), and the manuscript was prepared and revised according to the CARE Checklist (2016).

Open-Access: This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution NonCommercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <https://creativecommons.org/licenses/by-nc/4.0/>

Country/Territory of origin: China

ORCID number: Peng-Fei Zhou 0000-0001-7741-7785; Jia-Wen Wang 0000-0003-0979-7127.

S-Editor: Liu H

L-Editor: A

P-Editor: Yu HG

REFERENCES

- 1 Coskun A, Erkan N, Yakan S, Yildirim M, Cengiz F. Management of rectal foreign bodies. *World J Emerg Surg* 2013; **8**: 11 [PMID: 23497492 DOI: 10.1186/1749-7922-8-11]
- 2 Gash KJ, Suradkar K, Kiran RP. Rectal trauma injuries: outcomes from the U.S. National Trauma Data Bank. *Tech Coloproctol* 2018; **22**: 847-855 [PMID: 30264196 DOI: 10.1007/s10151-018-1856-4]
- 3 Goldberg JE, Steele SR. Rectal foreign bodies. *Surg Clin North Am* 2010; **90**: 173-184, Table of Contents [PMID: 20109641 DOI: 10.1016/j.suc.2009.10.004]
- 4 Lodhia J, Msuya D, Chilonga K, Makanga D. Successful Transabdominal Removal of Penetrating Iron Rod in the Rectum: A Case Report. *East Afr Health Res J* 2021; **5**: 137-141 [PMID: 35036838 DOI: 10.24248/eahrj.v5i2.663]
- 5 Sohrabi C, Mathew G, Maria N, Kerwan A, Franchi T, Agha RA; Collaborators. The SCARE 2023 guideline: updating consensus Surgical CAse REport (SCARE) guidelines. *Int J Surg* 2023; **109**: 1136-1140 [PMID: 37013953 DOI: 10.1097/JS9.0000000000000373]
- 6 Cawich SO, Thomas DA, Mohammed F, Bobb NJ, Williams D, Naraynsingh V. A Management Algorithm for Retained Rectal Foreign Bodies. *Am J Mens Health* 2017; **11**: 684-692 [PMID: 27903951 DOI: 10.1177/1557988316680929]
- 7 Ploner M, Gardetto A, Ploner F, Scharl M, Shoap S, Bäcker HC. Foreign rectal body - Systematic review and meta-analysis. *Acta Gastroenterol Belg* 2020; **83**: 61-65 [PMID: 32233273]
- 8 Husain R, Alghamdi DA, Ghzoi FA, AlArafah SK, Bahammam MA, Al Duhileb M. Conservative management of fish bone-induced large bowel perforation: Case report. *Int J Surg Case Rep* 2022; **95**: 107157 [PMID: 35569310 DOI: 10.1016/j.ijscr.2022.107157]
- 9 Caliskan C, Makay O, Firat O, Can Karaca A, Akgun E, Korkut MA. Foreign bodies in the rectum: an analysis of 30 patients. *Surg Today* 2011; **41**: 795-800 [PMID: 21626325 DOI: 10.1007/s00595-009-4362-5]
- 10 Yildiz SY, Kendirci M, Akbulut S, Ciftci A, Turgut HT, Hengirmen S. Colorectal emergencies associated with penetrating or retained foreign bodies. *World J Emerg Surg* 2013; **8**: 25 [PMID: 23849062 DOI: 10.1186/1749-7922-8-25]
- 11 Simbila AN, Suphian A, Ngowi NJ, Mfinanga RJ, Kilindimo S, Sawe HR. Colon perforation by foreign body insertion for sexual gratification: a case report. *Pan Afr Med J* 2021; **40**: 188 [PMID: 35059108 DOI: 10.11604/pamj.2021.40.188.32087]
- 12 Pinto A, Miele V, Pinto F, Mizio VD, Panico MR, Muzj C, Romano L. Rectal foreign bodies: imaging assessment and medicolegal aspects. *Semin Ultrasound CT MR* 2015; **36**: 88-93 [PMID: 25639182 DOI: 10.1053/j.sult.2014.11.002]
- 13 Clarke DL, Buccimazza I, Anderson FA, Thomson SR. Colorectal foreign bodies. *Colorectal Dis* 2005; **7**: 98-103 [PMID: 15606596 DOI: 10.1111/j.1463-1318.2004.00699.x]
- 14 Huang WC, Jiang JK, Wang HS, Yang SH, Chen WS, Lin TC, Lin JK. Retained rectal foreign bodies. *J Chin Med Assoc* 2003; **66**: 607-612 [PMID: 14703278]
- 15 Koornstra JJ, Weersma RK. Management of rectal foreign bodies: description of a new technique and clinical practice guidelines. *World J Gastroenterol* 2008; **14**: 4403-4406 [PMID: 18666334 DOI: 10.3748/wjg.14.4403]
- 16 Schellenberg M, Brown CVR, Trust MD, Sharpe JP, Musonza T, Holcomb J, Bui E, Bruns B, Hopper HA, Truitt MS, Burlew CC, Inaba K, Sava J, Vanhorn J, Eastridge B, Cross AM, Vasak R, Vercuysse G, Curtis EE, Haan J, Coimbra R, Bohan P, Gale S, Bendix PG; AAST Contemporary Management of Rectal Injuries Study Group. Rectal Injury After Foreign Body Insertion: Secondary Analysis From the AAST Contemporary Management of Rectal Injuries Study Group. *J Surg Res* 2020; **247**: 541-546 [PMID: 31648812 DOI: 10.1016/j.jss.2019.09.048]
- 17 Lefcourt T, Ku A, Issagholian L, Neeki AS, Retamozo M, Dong F, Neeki MM. Novel Bedside Utilization of Foley Catheter in the Emergent Removal of Colorectal Foreign Body: A Case Report and Literature Review. *Cureus* 2021; **13**: e20217 [PMID: 35004037 DOI: 10.7759/cureus.20217]



Published by **Baishideng Publishing Group Inc**
7041 Koll Center Parkway, Suite 160, Pleasanton, CA 94566, USA

Telephone: +1-925-3991568

E-mail: office@baishideng.com

Help Desk: <https://www.f6publishing.com/helpdesk>

<https://www.wjgnet.com>

