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Case Report

Delayed Diagnosis of Rectosigmoid Perforation Following Rectal Foreign Body Insertion Presenting with Septic Peritonitis: A Case Report

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Abstract

Background: Rectal foreign bodies (RFBs) represent an uncommon but potentially life-threatening surgical emergency. Delayed diagnosis of colorectal perforation can result in fecal peritonitis, sepsis, and increased mortality.

Case Presentation: A 20-year-old previously healthy man presented with severe generalized abdominal pain, fever, tachycardia, tachypnea, and clinical features of sepsis 24 hours after rectal foreign body insertion. He had initially attended another emergency department where anal examination was reportedly normal, and he was discharged with analgesics. On admission to our institution, physical examination demonstrated generalized peritonitis with a rigid abdomen. Laboratory investigations showed leukocytosis with neutrophilia and elevated inflammatory markers. An erect chest radiograph demonstrated free subdiaphragmatic air. Following aggressive resuscitation and intravenous broad-spectrum antibiotics, emergency exploratory laparotomy was performed. A perforation at the upper rectum (rectosigmoid junction) with generalized fecal contamination was identified. Primary repair of the perforation, extensive peritoneal lavage, and a protective loop ileostomy were successfully performed. The postoperative course was uneventful, and the patient was discharged on postoperative day seven with a plan for ileostomy closure after one month.

Conclusion: A normal anal examination does not exclude proximal colorectal perforation after rectal foreign body insertion.

Key words: emergency surgical practice

Introduction

Rectal foreign bodies are rare presentations in emergency surgical practice. Delayed diagnosis increases morbidity.

Case Presentation

A 20-year-old previously healthy male presented with generalized abdominal pain one day after rectal foreign body insertion. Initial assessment elsewhere was normal on anal examination and he was discharged with analgesics. At our hospital he was septic with a surgical abdomen. Emergency laparotomy revealed a perforation at the upper rectum (rectosigmoid junction) with fecal contamination. Peritoneal lavage, primary repair, and protective loop ileostomy were performed. The patient recovered well and was discharged after seven days with follow-up for ileostomy closure after one month.

Discussion

This case emphasizes that a normal anal examination does not exclude proximal colorectal injury. Early imaging and prompt surgery are essential.

Conclusion

Persistent abdominal pain after rectal foreign body insertion requires urgent evaluation despite normal anorectal findings.

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