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Total Mechanical Intestinal Obstruction due to Intrarectal Foreign Body: A Case Report and Comprehensive Literature Review on Surgical Approaches and Pathophysiological Analysis of the Suction Effect

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ABSTRACT

Introduction

Retained rectal foreign body (RFB) represents one of the most challenging and unique clinical presentations in surgical emergency departments worldwide. (1) This condition is often shrouded by social stigma, embarrassment, and cultural barriers, leading patients to delay seeking medical help until life-threatening complications, such as total mechanical intestinal obstruction or colonic perforation, develop. (1) This case report presents the surgical management of a young male patient with acute intestinal obstruction due to a plastic bottle lodged in the rectosigmoid area.

Case Illustration

A 24-year-old male presented to the emergency department complaining of a plastic bottle inserted into the anus one hour before hospital admission. The patient reported an inability to remove the object independently, accompanied by nausea, abdominal bloating, and loss of ability to pass flatus. Physical examination revealed increased bowel sounds and suprapubic tenderness. Laboratory examination revealed leukocytosis (13,440 / µL), indicating an initial inflammatory response to bowel distension. (6) Plain abdominal radiography (BNO) confirmed the presence of a cylindrical foreign body in the rectosigmoid area. The patient underwent emergency exploratory laparotomy for foreign body evacuation via the intra-abdominal "milking" technique after transanal extraction attempts failed.

Discussion

RFB management requires a "step-up" algorithm approach, ranging from bedside extraction to open surgical intervention. (11) The failure of manual extraction in this case was due to the large diameter of the bottle and the "suction effect," or vacuum effect, created against the rectosigmoid mucosa. (12) The use of broad-spectrum prophylactic antibiotics such as intravenous Ceftriaxone 1 g proved effective in preventing surgical site infection (SSI) in emergency colorectal surgery procedures. (15)

Conclusion

Early diagnosis through radiological imaging and careful clinical evaluation is crucial for determining a safe evacuation strategy. (18) Although transanal techniques are the first line, exploratory laparotomy remains the definitive choice to prevent iatrogenic injury in cases of foreign bodies tightly lodged in the proximal rectum. (9)

Keywords

Rectal Foreign Body, Mechanical Intestinal Obstruction, Exploratory Laparotomy, Rectosigmoid, Colon Pathophysiology.

INTRODUCTION

Background

The medical phenomenon of rectal foreign bodies (RFB) has been documented in medical literature for centuries, with the oldest recorded case dating back to the 16th century. (4) Although historically considered a rare or "odd" case, recent epidemiological data show a significant increasing trend in urban medical centers worldwide. (3) In the United States, the incidence of emergency department visits for RFB increased from 1.2 per 100,000 persons in 2012 to 1.9 per 100,000 persons in 2021. (21) This increase reflects shifts in societal sexual behavior, greater openness regarding unconventional sexual practices, and the wide availability of various objects or stimulation devices on the market. (3)

The majority of RFB cases are voluntary and related to sexual stimulation or anal autoeroticism, accounting for approximately 80% to 100% of clinical presentations in adult men. (3) However, there are also cases caused by accidents, self-treatment (such as attempts to disimpact fecal impaction), criminal assault, or concealment of contraband (body packing). (4) A wide variety of objects have been found lodged in the rectum, ranging from glass bottles, personal care products, fruits, vegetables, light bulbs, to exotic household items. (2) Bottles, whether glass or plastic, remain one of the most frequently reported objects, accounting for approximately 42.2% of all cases. (1)

The main challenge in RFB management lies not only in the extraction technique but also in the accompanying psychosocial barriers. Patients often feel very embarrassed, fear judgment from medical personnel, or worry about the confidentiality of their identity. (2) Consequently, many patients attempt to remove the object themselves using various other tools, which often pushes the object deeper into the sigmoid colon or causes additional mucosal injury. (2) This delay in seeking medical attention directly correlates with an increased risk of serious complications, such as total mechanical intestinal obstruction, bowel wall ischemia, perforation, and sepsis. (31)

Total mechanical intestinal obstruction caused by RFB occurs when the object is sufficiently large

to completely occlude the bowel lumen, preventing the passage of feces and gas. (4) This condition is a surgical emergency requiring immediate decompression to prevent bowel necrosis. (32) Furthermore, cylindrical objects with smooth surfaces, such as bottles, often create a strong vacuum effect against the colonic wall, making manual transanal evacuation nearly impossible without surgical intervention. (12)

Problem Formulation

Given the clinical and mechanical complexity of this case, several main issues need to be addressed in this case report study:

1. What are the clinical and radiological criteria indicating an urgent need for escalation from transanal extraction procedures to exploratory laparotomy in patients with RFB?
2. How does the physical mechanism of the "vacuum effect" in bottle-shaped objects hinder manual evacuation and increase the risk of rectosigmoid injury?
3. How does the laboratory profile of patients with acute intestinal obstruction due to RFB reflect the severity of inflammation and the risk of systemic complications?
4. To what extent is the effectiveness of prophylactic antibiotic protocols and postoperative supportive therapy in minimizing morbidity in patients undergoing emergency colorectal surgery?

Research Objectives

The objectives of this case report are:

1. To document and analyze in detail the clinical course of a 24-year-old male patient who suffered total mechanical intestinal obstruction due to an intrarectal bottle.
2. To evaluate the use of exploratory laparotomy as a safe and effective evacuation method when minimally invasive approaches are not feasible.
3. To conduct an in-depth literature review on the pathophysiology of distal obstruction and the RFB management algorithm based on the latest international guidelines from the World Society of Emergency Surgery (WSES).
4. To provide a reference for medical personnel in facing technical and psychosocial challenges in cases of retained foreign bodies in the colorectal area.

Research Benefits

This case report is expected to provide the following benefits:

1. Clinical Benefit: To provide practical guidance for surgeons and emergency department physicians regarding signs of failed manual extraction and when to decide on definitive surgical intervention.
2. Academic Benefit: To enrich knowledge in the field of digestive surgery, particularly regarding the management of non-neoplastic intestinal obstruction caused by foreign bodies.
3. Educational Benefit: To increase awareness of the importance of an empathetic and non-judgmental medical approach towards patients with RFB to accelerate diagnosis and reduce complications.
4. Epidemiological Benefit: To contribute to RFB case data in Indonesia, which is crucial for understanding behavioral patterns and clinical presentation patterns in the local population.

Hypothesis

The main hypothesis in this case report is that in patients with a rectal foreign body located in the rectosigmoid area causing total mechanical obstruction, exploratory laparotomy is the safest method of choice to prevent iatrogenic perforation if initial transanal extraction attempts fail due to the vacuum effect and anal sphincter spasm.

Research Gap

Although many publications exist on RFB, most of the literature consists of single case reports focusing on the uniqueness of the found object. (36) There is a lack of studies deeply analyzing the relationship between the physical characteristics of the object (such as volume and cylindrical shape) and the onset speed of total obstruction. Furthermore, in Indonesia, documentation of RFB management is still very rare, so there is no national consensus on a uniform initial management protocol at various levels of healthcare facilities. This study attempts to fill this gap by integrating local clinical data with global standard guidelines.

Novelty

The novelty of this case report lies in the patient's very rapid clinical presentation, only one hour after bottle insertion, yet already showing signs of total mechanical intestinal obstruction and

early leukocytosis. This suggests that mechanical obstruction due to RFB does not require days to develop into an emergency condition. Additionally, this report emphasizes the use of exploratory laparotomy without colotomy (milking maneuver) which successfully minimized peritoneal contamination, a crucial technical aspect often overlooked in standard surgical reports. (7)

CASE REPORT

Patient Identity and Chief Complaint

The patient was an Indonesian male, aged 24 years, who came to the emergency department of Primaya Hospital, Karawang, with the chief complaint of a foreign body in the form of a plastic bottle lodged in his anus. Based on information from the registration system and medical records, the patient's identity was recorded as A.R.A, a young adult male with no significant prior history of systemic disease. (39)

In-depth Anamnesis

The patient admitted to inserting the bottle into his anus approximately one hour before arriving at the hospital. The motivation behind this action was not explicitly disclosed by the patient, but clinically this condition is often associated with anal autoerotic behavior. (3) Shortly after insertion, the patient realized that the object had migrated further cranially and could no longer be reached by his hand. Independent attempts to strain and pull the object only caused increasingly severe pain. (2)

At the time of examination in the ED, the patient complained of the following symptoms:

- Persistent nausea, but without projectile vomiting.
- A feeling of abdominal bloating in the lower abdomen.
- Inability to pass gas (flatus) since the incident.
- No history of per rectal bleeding or mucus discharge from the anus.

Initial Physical Examination

Physical examination was performed systematically to assess hemodynamic stability and signs of primary intra-abdominal complications.

Vital Parameter	Examination Result	Clinical Interpretation
General Condition	Mildly Ill	Patient showing distress due to pain (5)
Consciousness	Compos Mentis (GCS E4M6V5)	Intact neurological function
Blood Pressure	110/81 mmHg	Hemodynamically stable (Normotensive)
Pulse Rate	83 x/minute	Regular, sufficient volume
Respiratory Rate	20 x/minute	Normal breathing pattern
Body Temperature	36.6 °C	Afebrile (No fever)
Oxygen Saturation	97% *on air*	Good tissue oxygenation

General Physical Examination:

- Head & Neck: Conjunctiva not anemic, sclera not icteric. No enlargement of cervical lymph nodes was found.
- Thorax: Chest wall movement symmetric during inspiration and expiration. Sonorous percussion over both lung fields. Normal vesicular breath sounds, no rhonchi or wheezing. Regular heart sounds I-II, no murmur.
- Abdomen:
    - Inspection: Abdomen appeared flat, with no obvious distention at first glance. No previous surgical scars or prominent masses were found.
    - Auscultation: Bowel sounds were significantly increased. This is a classic finding in the early phase of mechanical intestinal obstruction, where the bowel segment proximal to the obstruction increases its contractility to overcome the physical barrier. (34)
    - Palpation: The abdominal wall felt supple. However, there was clear tenderness in the suprapubic area. No muscular defense or rebound tenderness was found, indicating that generalized peritonitis had not yet occurred at that time.
    - Percussion: Tympanic sound throughout all abdominal quadrants, indicating air accumulation within the bowel lumen due to obstruction. (34)

- Anorectal: Digital rectal examination (DRE) was performed very cautiously. Although specific tactile details were not recorded, clinical diagnosis indicated that the foreign body was already beyond finger's reach in the upper rectal ampulla or rectosigmoid. (40)
- Extremities: Warm peripheries, CRT <2 seconds, no peripheral edema.

Laboratory Analysis

Laboratory examinations were performed for emergency surgical preparation and to assess the systemic response to intestinal obstruction.

Examination	Result	Reference Value	Unit
Routine Hematology			
Hemoglobin (Hb)	13.1	14.0 – 18.0	g/dL
Hematocrit	39.1	40.0 – 54.0	%
Leukocytes (WBC)	13,440	4,000 – 11,000	/µL
Platelets	378,000	150,000 – 440,000	/µL
Erythrocytes	4.54	4.50 – 5.90	million/µL
Erythrocyte Indices			
MCV	75.3	80.0 – 100.0	fL
MCH	25.6	27.0 – 32.0	pg
MCHC	32.5	32.0 – 36.0	g/dL
RDW-CV	13.8	11.5 – 14.5	%
Metabolism			
Glucose POCT	90	70 – 140	mg/dL
Coagulation			
Clotting Time (CT)	12	9 – 15	minutes
Bleeding Time (BT)	3	1 – 6	minutes

The most prominent laboratory finding was leukocytosis (13,440 / µL). (6) This increase in white blood cell count, despite the patient having symptoms for only one hour, indicates an initial physiological stress and inflammatory response to acute bowel wall distension. (7) The slightly low MCV, MCH, and MCHC levels indicate a picture of mild hypochromic microcytic anemia,

which might have been the patient's baseline condition prior to this acute event. (6) Normal coagulation parameters (CT 12 minutes and BT 3 minutes) provided safety for immediate surgical intervention.

Radiological Findings

Imaging is a crucial diagnostic step to determine the type, position, and number of foreign bodies, as well as to detect perforation. (11)

1. Abdominal AP Radiography (BNO):
    - A radiolucent foreign body (imaging a plastic bottle) shaped like a cylinder was seen projected over the rectosigmoid area.
    - Bowel gas distribution appeared normal in most areas, but there was prominent fecal material in the colorectal system.
    - Critical Note: Based on radiological expertise, no classic obstructive ileus signs (such as coil-spring appearance, air-fluid levels, or step-ladder phenomenon) were visible. This is very interesting because clinically the patient was diagnosed with total obstruction. This phenomenon can be explained by the very short onset (one hour), where massive bowel dilatation had not yet had time to form radiologically even though the mechanical blockage had already occurred completely.
    - No signs of free extraluminal air (pneumoperitoneum) were found, indicating that large bowel perforation had not yet occurred.
2. Thorax Radiography (PA):
    - Heart and lungs within normal limits.
    - CTR < 0.50, aorta not dilated, trachea midline.
    - Costophrenic angles sharp and diaphragm regular.
    - This examination confirmed that the patient had no systemic cardiopulmonary contraindications for undergoing general anesthesia. (42)

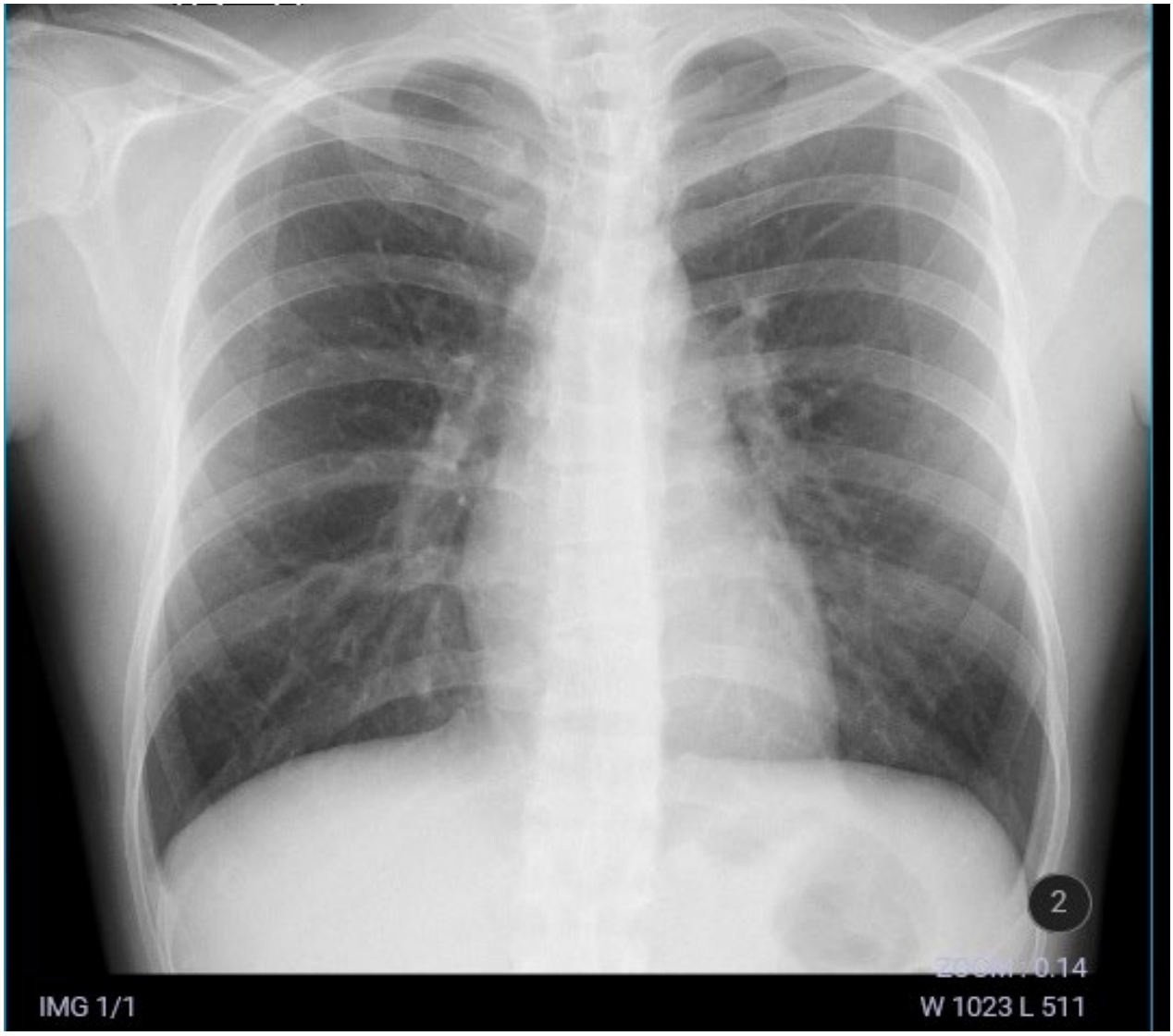

Figure 1. Thorax Radiography (PA)

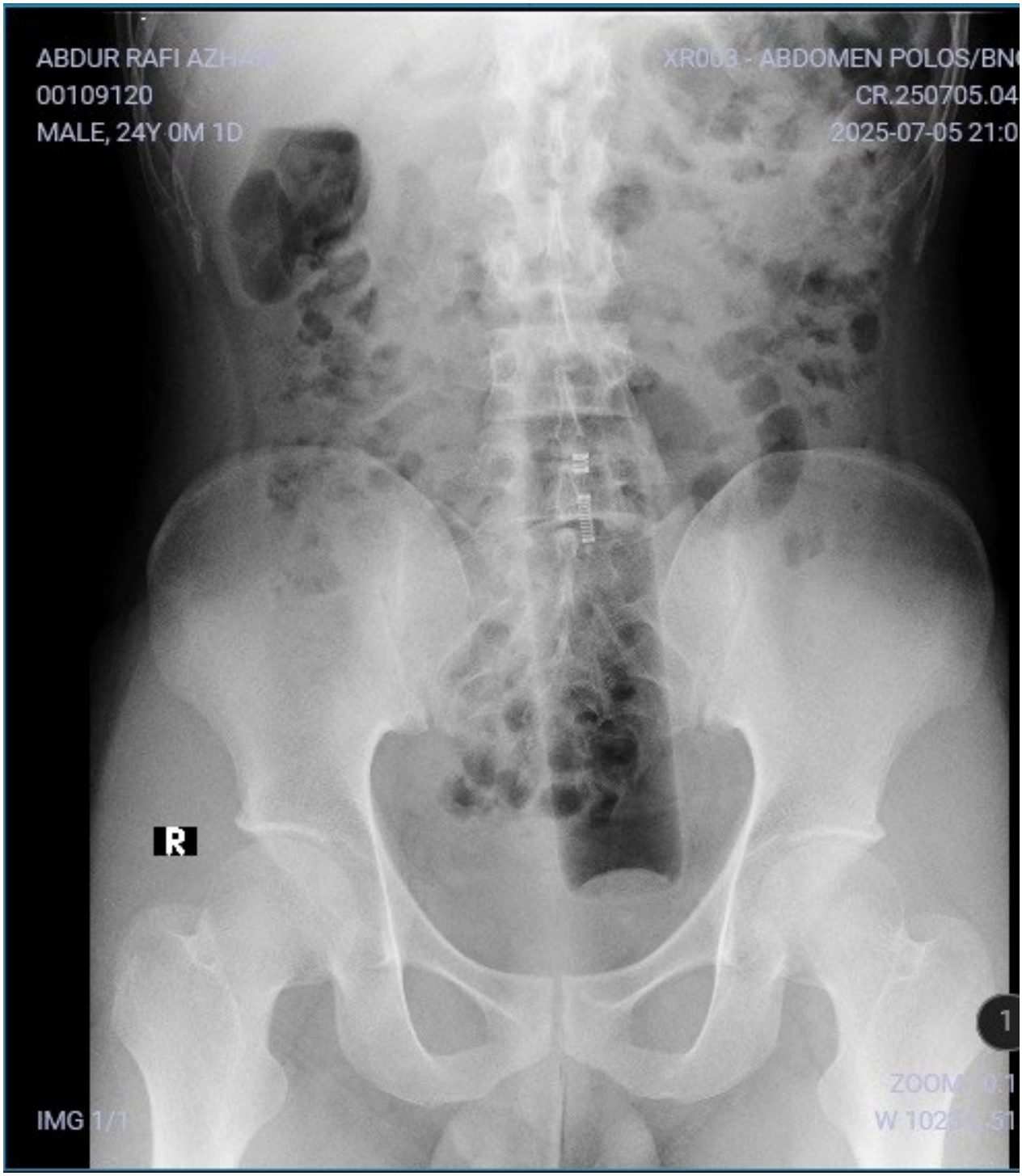

Figure 2. Abdominal AP Radiography (BNO)

Working Diagnosis

Based on the integration of clinical findings, increased bowel sounds, suprapubic tenderness, leukocytosis, and the image of a bottle on X-ray, the diagnosis was established as: Total Mechanical Intestinal Obstruction due to Intrarectal Foreign Body.

Surgical and Intraoperative Management

Given the signs of total obstruction and failure of manual evacuation in the ED (due to the high position of the bottle and pelvic muscle spasm), the surgical team decided to perform immediate (CITO) surgical intervention.

Preoperative Preparation:

- Placement of an intravenous line with Ringer's Acetate solution 21 drops per minute for initial fluid resuscitation.
- Administration of prophylactic antibiotic Inj. Ceftriaxone 1 g intravenously one hour before anesthesia induction. The choice of a third-generation cephalosporin aimed to provide protection against Gram-negative pathogens dominating the proximal intestinal flora. (15)

Operative Steps:

1. The patient underwent general anesthesia with endotracheal intubation to achieve maximal abdominal muscle relaxation. (43)
2. Exploratory laparotomy was performed via a midline incision. After the peritoneal cavity was opened, the descending and sigmoid colon were identified. (7)
3. A cylindrical plastic bottle was found tightly lodged at the rectosigmoid junction. The proximal bowel wall appeared slightly edematous due to acute distension.
4. The surgical team chose the "milking maneuver" technique. Through careful manual manipulation of the bowel wall, the bottle was slowly pushed caudally (toward the anus). (7) This technique was crucial because it successfully expelled the foreign body without performing a colotomy (incision into the bowel wall), thus avoiding the risk of fecal contamination into the peritoneal cavity. (9)
5. A surgical assistant on the distal side received the bottle through the anus as it was pushed from above. The successfully removed bottle was a orange plastic bottle with a purple cap,

having a smooth and slippery surface. (46)

6. After the bottle was removed, the intestinal mucosa was inspected. No signs of perforation or active bleeding were found, only mild hyperemia in the area where the bottle had been lodged. (47)
7. The abdominal cavity was cleaned, bleeding controlled, and the surgical wound was closed layer by layer.

Figure 3. Intraoperative Images

Postoperative Course

Postoperatively, the patient was observed in the recovery room. The patient's hemodynamic status was stable with blood pressure 121/78 mmHg and pulse rate 68 x/minute. The patient reported minimal pain at the surgical incision site and did not experience fever.

Postoperative Medical Orders:

- IVFD Ringer's Acetate 21 drops/minute.
- Ceftriaxone 2 x 1 g IV (Continued antibiotic during hospitalization).
- Ranitidine 2 x 50 mg IV (Stress ulcer prophylaxis).
- Dexketoprofen 3 x 50 mg IV (Potent analgesic for post-laparotomy pain).

Based on rapid recovery, where bowel sounds had returned to normal and there were no signs of intra-abdominal complications, the patient was planned for outpatient care on the same afternoon with instructions for daily wound care. Discharge medications included Cefixime 2 x 200 mg PO, Ranitidine 2 x 150 mg PO, and Mefenamic Acid 3 x 500 mg PO.

DISCUSSION

Epidemiological Analysis and Patient Characteristics

Rectal foreign body (RFB) cases are often a subject of complex medical discussion as they encompass various aspects, from surgical technique to profound psychosocial dimensions. Epidemiologically, there is a very consistent pattern worldwide: the majority of patients are male, with a ratio ranging from 2:1 to 37:1 compared to females. (41) The patient's age in this case, 24 years, falls within the peak range of the bimodal distribution for RFB. (21) The first peak occurs in the second and third decades (20s), generally related to sexual exploration or anal autoeroticism. The second peak is seen in the 60s, more often associated with attempts at self-treatment for chronic constipation or prostate massage. (8)

Recent data from studies in the United States show that 55.4% of RFBs found are sexual devices (such as vibrators), followed by household products like bottles and glasses. (1) The use of plastic bottles, as in patient A.R.A's case, presents slightly different risks compared to glass bottles. Plastic bottles tend to be more elastic and less likely to break, but their smooth surface

actually strengthens the vacuum effect that complicates manual extraction. (12)

Anatomy and Mechanical Dynamics of the Rectosigmoid

To understand why foreign bodies often become lodged in the rectosigmoid area, we must review the distal anatomy of the large intestine. The rectum is approximately 12 to 15 cm long and follows the sacral curvature. (1) Inside the rectum, there are three transverse mucosal folds known as the *Valves of Houston*. Objects inserted through the anus can often pass these valves with the aid of lubrication, but upon reaching the rectosigmoid junction, the large intestine undergoes narrowing and an acute angle change. (19)

In this case, the plastic bottle reached the rectosigmoid area. When an object with a diameter approaching or exceeding the diameter of the bowel lumen is in this position, several mechanical mechanisms occur:

1. Sphincter Spasm: The entry of a foreign object triggers a reflex contraction of the internal and external anal sphincters as a bodily defense against the foreign object. This contraction effectively "locks" the object within the lumen. (4)
2. Vacuum Effect (Suction Effect): A closed, cylindrical bottle creates an airtight seal against the intestinal mucosa. When the patient attempts to strain or when medical staff try to pull the bottle out, negative pressure is created in the cranial (upper) part of the object. (12) This negative pressure acts like a suction, pulling the bowel wall toward the bottle, increasing the coefficient of friction and preventing the object from moving distally. (43)
3. Houston Valve Obstruction: The rectal mucosal folds act as one-way physical barriers. Objects are easier to push in than to pull out because these valves will "catch" the object's edge when pulled downwards. (30)

Pathophysiology of Distal Mechanical Intestinal Obstruction

The diagnosis of total mechanical intestinal obstruction in this patient was supported by clinical findings including loss of ability to pass flatus and increased bowel sounds. (34) The pathophysiology of this condition can be analyzed through several critical stages:

- Accumulation of Gas and Fluids: Proximal to the obstructing bottle, swallowed air and digestive secretions accumulate. Intraluminal pressure increases progressively. (32)

Although the initial X-ray did not show massive air-fluid levels, increased bowel sounds indicated that the intestine was compensating with strong peristalsis. (32)

- Bowel Wall Edema: Increased intraluminal pressure disrupts venous and lymphatic drainage from the bowel wall. This leads to venous congestion and interstitial edema. (32) If intraluminal pressure continues to rise beyond arterial perfusion pressure, mucosal ischemia will occur, potentially leading to transmural necrosis and perforation. (32)
- Bacterial Translocation and Leukocytosis: Damage to the mucosal barrier due to excessive distension allows Gram-negative bacteria (such as *Escherichia coli*) and endotoxins to shift into the lymphatic system and bloodstream. (1) The finding of leukocytosis of 13,440 / µL in this patient reflects the initial systemic response to mucosal barrier disruption and the threat of intra-abdominal infection. (6)

Role of Imaging in Management Strategy

Plain abdominal radiography remains the first-line imaging modality in RFB evaluation due to its wide availability and ability to quickly detect pneumoperitoneum. (11) In this case, the BNO X-ray showed the cylindrical bottle but noted "no signs of ileus seen." This is a very important clinical insight; the absence of classic radiological ileus signs in the first hour after the event should not diminish clinical suspicion of total obstruction.

Literature suggests using Contrast-Enhanced Computed Tomography (CT) scan of the abdomen-pelvis if there is strong suspicion of perforation not visible on plain radiography, or if the foreign body is radiolucent, such as thin plastic. (1) CT scan is also very helpful in determining the spatial relationship of the object to other pelvic structures. (4)

Extraction Algorithm: From Conservative to Surgical

RFB management must follow a systematic approach to minimize the risk of iatrogenic injury.

Intervention Level	Method	Success Criteria/Indications	References
First Line (ED)	Manual transanal extraction, Valsalva maneuver, suprapubic	Low-lying object, stable, not sharp.	(11)

	pressure		
Second Line (OR)	Transanal extraction under anesthesia (spinal/general) for sphincter relaxation	Failed manual extraction, high position, severe pain.	(26)
Third Line (OR)	Endoscopic assistance (snares, Foley catheter to break vacuum)	Small object in sigmoid colon, no signs of perforation.	(11)
Fourth Line (OR)	Exploratory laparotomy ("milking" technique or colotomy)	Total obstruction, impacted, signs of peritonitis.	(9)

In patient A.R.A, direct escalation to exploratory laparotomy was performed after minimally invasive attempts were deemed inadequate to address the bottle located high in the rectosigmoid. The use of the intra-abdominal "milking" technique, where the surgeon manually pushed the object from outside the bowel towards the anus, proved highly effective. (7) This technique is preferred over colotomy (opening the bowel) because it maintains luminal integrity, prevents leakage of bowel contents into the peritoneal cavity, and significantly reduces the risk of postoperative complications such as abscess or adhesions. (9)

Pharmacotherapy and Prophylactic Antibiotics

The administration of prophylactic antibiotics, Ceftriaxone 1 g IV before surgery, was a crucial step. In emergency colorectal surgery, the risk of surgical site infection (SSI) can reach 30%. (17) Ceftriaxone, as a third-generation cephalosporin, provides good coverage against Gram-negative bacteria, but many recent guidelines recommend the addition of Metronidazole to cover the abundant anaerobic bacteria in the colon. (5) Nevertheless, the use of Ceftriaxone alone in an emergency setting like this still provides substantial benefit in reducing postoperative morbidity. (45)

The use of postoperative analgesics also requires attention. Dexketoprofen 3 x 50 mg IV given to this patient is a potent non-steroidal anti-inflammatory drug (NSAID) for post-

laparotomy pain management. NSAID use is often preferred over high-dose opioids in the early postoperative period because opioids can slow the recovery of bowel motility (postoperative ileus). (42)

Complications and Long-term Prognosis

Although the patient in this case showed rapid recovery and was allowed outpatient care on the same day, it is important to be aware of potential long-term complications from RFB and surgical trauma:

1. Fecal Incontinence: Injury to the anal sphincter muscles due to excessive manipulation or the use of large retractors can cause future defecation control disorders. (36)
2. Rectal Stenosis: The healing process from extensive mucosal lacerations can lead to scar tissue formation (stricture) that narrows the rectal lumen. (60)
3. Delayed Perforation: Pressure necrosis of the bowel wall due to a tightly lodged foreign body may not be immediately visible during surgery but can cause secondary perforation several days later. (7)
4. Psychological Impact: This event can cause psychological trauma or anxiety in the patient. Psychiatric evaluation is often recommended for patients with repetitive foreign body insertion behavior patterns to identify underlying psychiatric disorders or sexual dysfunction. (20)

CONCLUSION

This case report regarding total mechanical intestinal obstruction due to an intrarectal foreign body in patient A.R.A confirms several important points in modern surgical practice:

1. Importance of Clinical Diagnosis: Total mechanical intestinal obstruction can occur very shortly after insertion of a large-volume foreign body. Medical personnel should not rely solely on classic radiological signs (such as air-fluid levels) that may not appear in the early phase, but rather prioritize clinical findings such as increased bowel sounds and inability to pass flatus.
2. Advantage of Strategic Exploratory Laparotomy: When the foreign body is located high in

the rectosigmoid and is lodged by a vacuum seal and muscle spasm, exploratory laparotomy with the intra-abdominal "milking" technique is a safe and effective approach. This method successfully avoided colotomy, thereby reducing the risk of fecal contamination and accelerating patient recovery.

3. Early Inflammatory Response: The presence of leukocytosis (13,440 / µL) in the early phase of symptom onset is a sensitive indicator of significant bowel wall distension and should be heeded as a danger sign before progressing to ischemia or transmural perforation.
4. Adequate Supportive Management: The use of third-generation cephalosporin prophylactic antibiotics and appropriate non-opioid analgesia regimens greatly assists the success of a rapid postoperative recovery program (ERAS), allowing patients to be discharged for outpatient care in a short time if there are no intra-abdominal complications.

Overall, managing rectal foreign body cases requires a balance between surgical technical skill, diagnostic acumen, and empathy for patient privacy. The documentation of this case is expected to enrich emergency colorectal protocols and improve patient safety in facing this complex medical condition.

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