

When Hygiene Turns Hazardous: An Unusual Case of Rectosigmoid Impaction by a Health Faucet Requiring Laparotomy-Assisted Extraction

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Abstract

Rectal foreign bodies (RFBs) represent an uncommon but challenging surgical emergency. While most cases result from intentional insertion for sexual gratification, accidental insertion is exceedingly rare. Management depends on the size, shape, location, and associated complications of the foreign body. We present a rare case of patient-reported rectal insertion of a health faucet nozzle resulting in rectosigmoid impaction that required laparotomy-assisted transanal extraction. A 40-year-old male presented with anorectal pain, scant bleeding per rectum, mucoid discharge, and lower abdominal pain following an accidental slip-and-fall injury in the bathroom while defecating. Clinical examination revealed a palpable RFB. Plain radiographs demonstrated a foreign body consistent with a plastic health faucet impacted at the rectosigmoid junction. Due to the object's large size, irregular configuration, and proximal location, transanal extraction was considered unsafe. The patient underwent an exploratory laparotomy, during which the foreign body was carefully milked distally to disengage the entrapped rectal mucosa and subsequently extracted transanally without enterotomy or bowel resection. Intraoperative findings included localized rectal wall bruising and mucosal edema without perforation. The patient had an uneventful postoperative course, characterized by the return of bowel function and satisfactory recovery, and was subsequently discharged in stable condition. Accidental rectal insertion of a health faucet is an exceptionally rare cause of rectosigmoid foreign body impaction. This case highlights the importance of careful clinical assessment, appropriate imaging, and individualized operative planning. Laparotomy-assisted transanal extraction can be a safe and effective strategy for the removal of large, impacted rectosigmoid foreign bodies while preserving bowel integrity and avoiding more extensive surgical procedures.

Categories: General Surgery, Radiology, Emergency Medicine

Keywords: foreign body extraction, health faucet, rectal foreign body, rectosigmoid impaction, surgical emergency, transanal retrieval

Introduction

Rectal foreign bodies (RFBs) are an uncommon but increasingly encountered surgical emergency that poses significant diagnostic and therapeutic challenges to the treating surgeon [1]. The spectrum of retained RFBs is broad and includes sexual devices, household objects, bottles, fruits, and various other miscellaneous items [2]. Patients commonly present with anorectal pain, rectal bleeding, mucous discharge, constipation, abdominal pain, or, in severe cases, features of bowel perforation and peritonitis [3]. Embarrassment and reluctance to disclose the history frequently result in delayed presentation, increasing the risk of complications and making management more challenging [4]. Plain radiography plays an important role in the initial evaluation by helping determine the size, shape, orientation, and location of the foreign body as well as identifying evidence of perforation [2]. Although the majority of RFBs can be successfully removed using transanal techniques, impacted objects located in the upper rectum or rectosigmoid junction may require operative intervention, including laparoscopic or open surgical approaches [3].

Accidental insertion of a health faucet into the rectum is an exceptionally rare mechanism of injury, with very few similar cases described in the literature. Such objects may become impacted because of their irregular shape and transverse components, thereby complicating retrieval. This report describes a rare case of accidental insertion of a plastic health faucet into the rectum, resulting in impaction at the rectosigmoid junction that required laparotomy-assisted transanal extraction.

Case Presentation

A 40-year-old male with a known history of type 2 diabetes mellitus and systemic hypertension presented to the surgical outpatient department 15 hours after accidental rectal insertion of a health faucet following a slip-and-fall episode while defecating at home. The incident occurred while the patient was in a squatting position over a Western-style toilet, resulting in the health faucet becoming impacted within the rectum.

Immediately following the injury, he developed acute-onset perianal pain, which was sharp in nature and mild to moderate in intensity. This was associated with scant, self-limiting bright red bleeding per rectum

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and copious, non-foul-smelling mucoid rectal discharge. He also complained of lower abdominal pain that was insidious in onset, gradually progressive, dull aching, mild to moderate in intensity, non-radiating, and without identifiable aggravating or relieving factors. There was no history of vomiting or abdominal distension. The patient passed flatus on the morning following the injury, while the last bowel movement had occurred before the incident.

On presentation, the patient was conscious, cooperative, and oriented to time, place, and person. He was hemodynamically stable, with a pulse rate of 82 beats/minute, blood pressure of 128/92 mmHg, oxygen saturation of 99% on room air, and was afebrile.

Abdominal examination revealed a soft, non-distended abdomen without tenderness, guarding, or rigidity. Bowel sounds were present.

Perianal examination demonstrated an area of erythema measuring approximately 4 × 3 cm over the right side of the natal cleft adjacent to the anal verge. Skin tags were noted at the 6 o'clock and 12 o'clock positions, with anal fissures present at the 5 o'clock and 9 o'clock positions. Digital rectal examination revealed lax anal sphincter tone. The distal end of a hard tubular foreign body was palpable approximately 1 cm proximal to the anal verge and extended proximally for an estimated 5-7 cm. The examining finger could be passed circumferentially around the object up to approximately 7 cm, beyond which further advancement was not possible, suggesting impaction at the rectosigmoid junction. An attempt at transanal extraction in the outpatient department was unsuccessful.

Plain radiography of the abdomen (erect anteroposterior and lateral views) demonstrated a radiolucent foreign body within the rectosigmoid region, consistent with a plastic health faucet (Figure 1).



FIGURE 1: Erect X-ray of the abdomen in anteroposterior view showing the radio-opaque margins of the foreign body impacted in the rectosigmoid junction.

Arrowhead pointing to the foreign body.

Surgical technique

Under general anesthesia, the patient was placed in the lithotomy position. Transanal extraction was attempted but was unsuccessful; therefore, a midline laparotomy was performed. The foreign body was readily palpated within the rectosigmoid. Careful inspection revealed no evidence of perforation or breach of the rectal wall.

The foreign body was milked into the sigmoid to dislodge the rectal mucosa that was stuck between the faucet and the handle. The patient was placed in lithotomy position, then the foreign body was gently manipulated and pushed distally toward the rectum while simultaneous controlled traction was applied per anally. This coordinated maneuver facilitated successful transanal delivery of the foreign body without the need for enterotomy (Figure 2). Following extraction, minimal blood-stained mucoid discharge was noted. Subsequent assessment of the anal canal and rectum demonstrated intact mucosa with only minimal edema and evidence of a few mucosal tears but no active bleeding. Intra-abdominal evaluation revealed localized bruising over the right lateral wall of the rectum, with no signs of perforation or ongoing hemorrhage (Figure 3).



FIGURE 2: Extracted foreign body (health faucet).

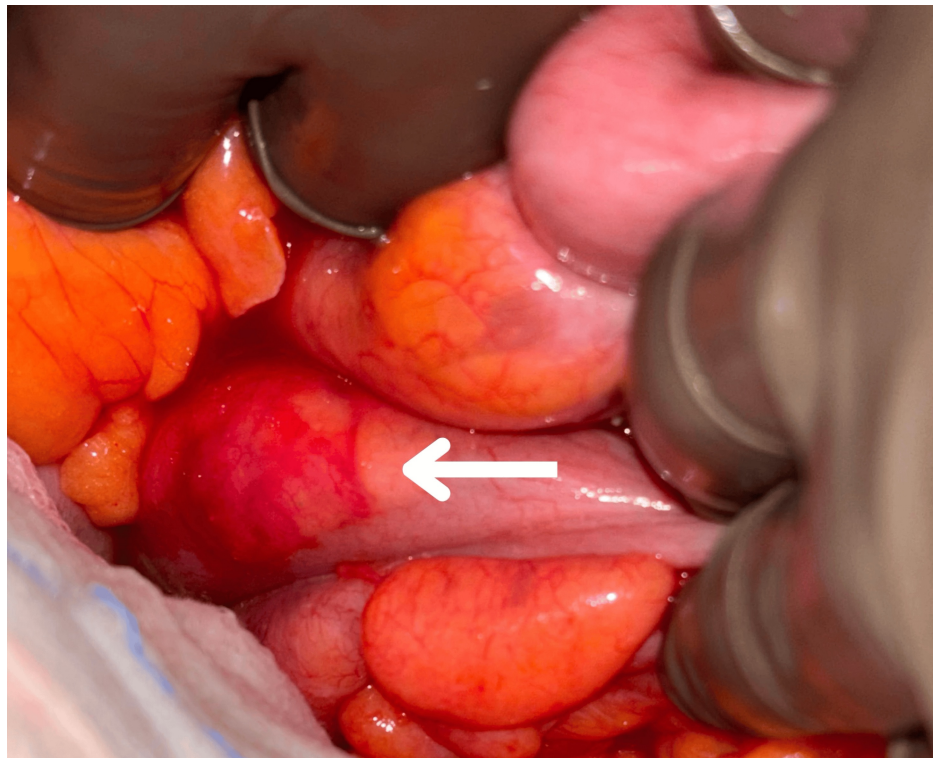


FIGURE 3: Intraoperative image showing the edema of the rectal mucosa.

Arrowhead pointing toward the rectal mucosal edema.

Thorough irrigation of the operative field was performed. A 28 French abdominal drain was placed in the pelvic cavity. The abdominal incision was then closed in layers in the standard fashion. The patient tolerated the procedure well and was transferred to the recovery unit in a hemodynamically stable condition.

Postoperative course

The postoperative period was uneventful, and the patient remained hemodynamically stable throughout hospitalization. There was no evidence of active bleeding or signs of peritonitis. The pelvic drain was removed on postoperative day (POD) 2 following satisfactory clinical assessment and absence of significant output.

Return of bowel function was confirmed by the presence of bowel sounds, and a liquid diet was initiated on POD 3. The diet was subsequently advanced to a soft diet on POD 5 without intolerance. By POD 6, the patient was passing normally formed stools without blood or mucus. Colonoscopy on POD 10 showed scattered superficial ulcers and an anal fissure.

Discussion

RFBs represent an uncommon but clinically significant surgical emergency, requiring prompt diagnosis and careful management to prevent complications. Most reported cases involve intentional insertion for sexual gratification; however, accidental insertion, as seen in this case, is exceedingly rare and presents unique diagnostic and technical challenges [1-3]. The unusual mechanism in this patient, i.e., a slip-and-fall injury leading to rectal insertion of a plastic health faucet while defecating, highlights the need to consider RFBs as one of the differentials and non-sexual causes of their insertion in patients presenting with anorectal pain and rectal bleeding.

The clinical presentation observed in this case is consistent with previously reported features of RFBs, including anorectal pain, rectal bleeding, mucoid discharge, and lower abdominal discomfort [3]. Delayed presentation due to embarrassment is frequently described, as was seen even in this patient. The patient provided an incomplete history, and after examination, the history was clarified when the patient provided complete information. Prompt history taking and clinical examination helped in early diagnosis and intervention [4]. Digital rectal examination remains the cornerstone of initial evaluation, allowing assessment of the location, orientation, and mobility of the foreign body. In this case, the palpable tubular structure with partial trapping of rectal mucosa between the handle and the faucet suggested impaction and

raised concern regarding mucosal injury during extraction.

Plain radiography serves as the initial imaging modality in stable patients with suspected RFBs, as it aids in determining the size, orientation, and location of the object, as well as identifying perforation [2]. In the present case, radiographs confirmed localization of the object to the rectosigmoid region. Although plastic objects may be relatively radiolucent, indirect signs such as contour outline and gas patterns can assist diagnosis. Advanced imaging is generally reserved for suspected perforation or diagnostic uncertainty. In this case, the metallic components of the faucet, along with the contour that was visible on X-ray, eliminated the requirement for any further imaging to identify the foreign body.

The management of RFBs requires a stepwise approach aimed at safe extraction while minimizing trauma to the rectum and colon [3]. Most low-lying objects can be removed transanally; however, large, high-lying, or irregularly shaped objects may require operative intervention [2]. In this case, the foreign body was large, irregular, and impacted at the rectosigmoid junction, making transanal extraction unsafe. Therefore, a laparotomy-assisted transanal extraction was performed, allowing controlled manipulation and safe retrieval without the need for an enterotomy.

Operative intervention is indicated in cases where transanal extraction is unsuccessful, when the object is located high in the rectum or sigmoid colon, or when complications such as perforation, ischemia, or peritonitis are suspected [2-4]. Intraoperatively, although no perforation was identified, localized rectal wall bruising was noted, likely due to pressure effects. As the bowel wall was intact, there was no need for a diversion procedure or bowel resection.

Mucosal injury is a recognized complication associated with both the presence and removal of RFBs. In this case, the development of a circumferential mucosal fissure on POD 2 was likely secondary to sustained pressure and manipulation during extraction. Importantly, the absence of full-thickness injury, active bleeding, or contamination allowed successful conservative management. The uneventful postoperative recovery, with early restoration of bowel function and resolution of symptoms, underscores the importance of timely intervention before progression to severe complications such as perforation or sepsis [1-3].

Few reports exist describing accidental insertion of health faucets into the rectum. A similar case described successful extraction under anesthesia without bowel injury [5]. However, the present case involved a larger, impacted object at the rectosigmoid junction requiring laparotomy-assisted extraction, thereby contributing valuable insight into the management of such rare presentations.

This case highlights several important clinical considerations. A nonjudgmental and empathetic approach is essential to obtain an accurate history in patients presenting with RFBs. Careful clinical examination and appropriate imaging are critical in guiding management. Large, irregular, or impacted objects often require operative assistance for safe removal. Finally, thorough post-extraction assessment for mucosal injury or perforation is mandatory, even in the absence of gross intraoperative findings.

A similar mechanism involving accidental rectal insertion of a hand shower has been reported by Kumar et al., who described successful transanal extraction under anesthesia without evidence of bowel injury. However, the present case differs significantly in several important aspects. First, the foreign body in our patient was considerably larger in size and possessed an irregular configuration with a transverse component, which predisposed it to impaction at the rectosigmoid junction. In contrast, previously reported cases involving smoother or more linear objects were more amenable to simple transanal removal [6].

Additionally, the level of impaction in our case was higher, involving the rectosigmoid junction rather than the distal rectum. High-lying foreign bodies are well recognized in the literature as being more difficult to manage and are more likely to require operative intervention due to limited accessibility and increased risk of mucosal injury during blind extraction attempts [1-3]. This anatomical factor played a crucial role in determining the management strategy, necessitating laparotomy-assisted transanal extraction rather than standard transanal techniques.

Furthermore, the presence of partial embedding of the foreign body into the rectal mucosa, particularly the posterior handle component, added another layer of complexity. This feature increased the risk of mucosal tearing or even perforation if forceful transanal retrieval had been attempted. Similar challenges with irregular and impacted objects have been described in prior studies, where surgical assistance was required to facilitate safe removal while minimizing iatrogenic injury [2].

Unlike some cases reported in the literature that required colotomy or bowel resection due to perforation or ischemic changes, our patient did not demonstrate full-thickness rectal injury, allowing preservation of bowel integrity [1]. This favorable outcome can be attributed to early presentation, careful preoperative evaluation, and a controlled operative approach combining abdominal and transanal techniques.

Another distinguishing feature of this case is the nature of the foreign body itself. Health-faucet-related rectal injuries are extremely rare, with very few cases documented [5]. Most studies predominantly

describe objects inserted intentionally for sexual gratification, such as bottles, dildos, or other household items [2,3]. The accidental mechanism in this case underscores the need for clinicians to maintain a high index of suspicion for atypical etiologies, particularly in patients presenting with vague anorectal symptoms following domestic accidents.

Overall, this case contributes to the limited body of literature on accidental RFBs, particularly those involving complex, irregularly shaped objects such as health faucets. It highlights that while many RFBs can be managed conservatively or with transanal techniques, a subset of patients with large, impacted, or proximally located objects may require laparotomy-assisted extraction to ensure safe and successful outcomes while minimizing complications.

Conclusions

Accidental rectal insertion of a health faucet is an extremely rare presentation of anorectal trauma. Early diagnosis, appropriate imaging, and a tailored surgical strategy enabled successful laparotomy-assisted transanal extraction in this patient without bowel perforation or need for enterotomy. This case adds to the limited literature on unusual RFBs and emphasizes the importance of individualized management to achieve optimal outcomes.

This case emphasizes several important clinical points: a nonjudgmental approach is essential to obtain an accurate history in patients with RFBs; careful digital rectal examination and plain radiography are crucial in initial assessment; large or impacted objects at the rectosigmoid junction may require operative assistance for safe removal; post-extraction evaluation for mucosal injury or perforation is mandatory, even when gross bowel injury is absent.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

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Disclosures

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