Intra Peritoneal Rectal Tear: Delayed Presentation in a Battered Baby

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Abstract
We report a two and a half year old child who presented with an acute abdomen two days after a spoon was forcefully inserted per rectum. The child recovered after repair of the rectal tear and a temporary sigmoid colostomy.

Key words: Acute abdomen, trauma, colostomy

An unusual case of delayed presentation of an intra peritoneal rectal tear, caused by deliberate insertion of a spoon per rectum, is reported.

A two and a half year old male child presented with a history of forced introduction of a spoon per rectum, two days prior, by his stepfather. The child had bleeding per rectum and was treated by a local doctor conservatively. He was brought to us with absolute constipation, distension of abdomen and fever. On examination, the child had fever of 40°C and pulse of 120 min, and the abdomen showed generalised distension. There was tenderness in the abdomen, more so in the lower abdomen. Bowel sounds were absent. Digital examination revealed a 2 cm long tear, 3 cm from the anal verge, on the anterior wall of the rectum. Scout film of the abdomen showed multiple air-fluid levels in the pelvis, there was no free gas under the domes.

Immediate exploration was undertaken by a supra-umbilical transverse incision. The small bowel loops were found to be distended and there was a pocket of 50 ml of purulent fluid in the pelvis, well localised by the bowel loops. A rectal tear on the anterior wall of the rectum just above the peritoneal reflection was identified. After freshening the edges the tear was sutured in two layers by interrupted 2-0 messilk. The suture line was reinforced by the rectosigmoid peritoneal fold. Peritoneal toilet was performed with saline and the abdomen was closed in mono layer, after exteriorising the sigmoid colon by a second separate incision. The sigmoid colostomy was matured after 48 hours. The patient had an uneventful post operative recovery and was discharged on the 7th day. Six weeks later a distal colostogram showed no leak or narrowing. Subsequently the colostomy was closed by an intra peritoneal approach.

Foreign bodies in the anorectum usually lacerate the rectal mucosa but rarely produce perforation. Most of these foreign bodies can be retrieved by per anal manipulation under adequate relaxation and rarely require exploratory laparotomy for extraction. But even after these are retrieved, either by the patient or by the physician, the patient needs careful inpatient observation, to rule out delayed complications like bleeding per rectum, perianal suppuration, fistulation and peritonitis.2,3,4 Emergency laparotomy may be indicated rarely, for removal of the foreign body or for peritonitis. After extraction of the foreign body and closure of the colonic tear a proximal diverting colostomy may be performed, as in our case. It is usually preferable to have a proximal diversion, as the colon cannot be adequately prepared prior to the surgical procedure.2,5 However, in early or clean cases a proximal diversion may be avoided.5

References

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