2018

Dynamic Practice Guidelines for Emergency General Surgery

Committee on Acute Care Surgery, Canadian Association of General Surgeons

15

LOWER GI FOREIGN BODIES

Dynamic Practice Guidelines for Emergency General Surgery

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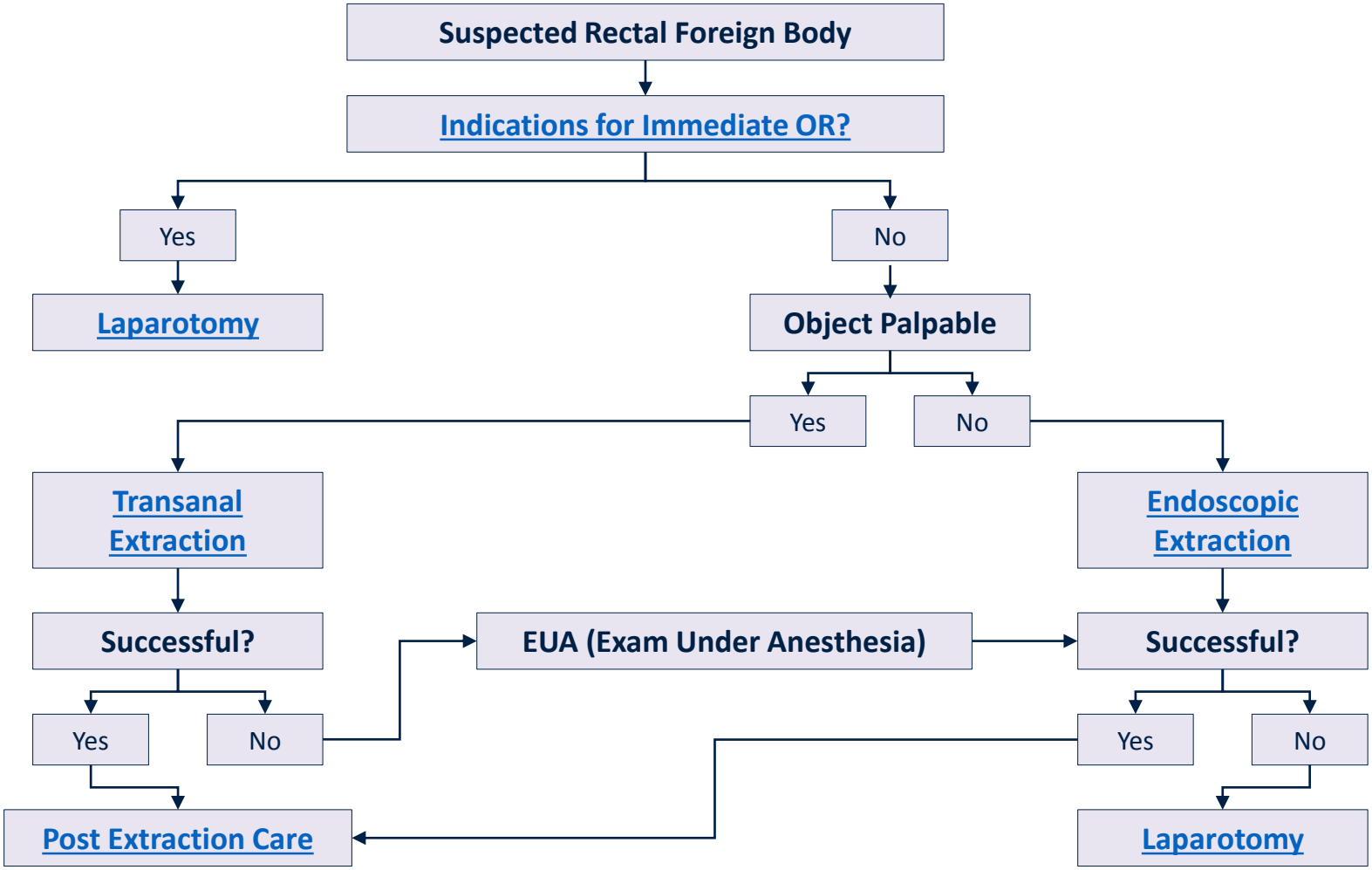
Clinical Practice Guideline

LOWER GI FOREIGN BODIES



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BACKGROUND

- Majority found in males
- All ages
- Many reasons although usually sexual in nature; however, must consider concealment/body packing as well
- >40% of items are glass/bottles
- Be non-judgmental as much as possible

Smith and Wong, 2007 Gastrointest Endosc Clin N Am

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PRESENTATION AND WORK-UP

- Maintain a high index of suspicion
- Look for signs necessitating immediate OR **URGENT**
  - Unstable patient, peritonitis, free air on imaging
- Plain x-rays are not absolutely necessary although can be “interesting”
- Location/shape can predict transanal removal – sigmoid location 2.5x more likely to require OR

Lake, Essani, Petrone, et al, 2004 Dis Colon Rectum

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TRANSANAL EXTRACTION

- Initially attempt in ER
  - Local anesthesia (perianal ring block) +/- IV sedation
- Aids
  - Assistant applying abdominal pressure
  - Valsalva maneuver
  - Lubrication
  - Grasping instruments – Kocher, ring forceps, Gyne tenaculum
  - Foley (24F 30cc balloon)
    - Insert past FB (breaks the rectal seal) then inflate balloon and use to apply traction
- Other considerations
  - Avoid breaking glass
  - Avoid rupture of devices/bags carrying drugs

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LOWER ENDOSCOPIC EXTRACTION

- Methods of extraction
  - "Lasso" with polypectomy snare
  - Biopsy forceps to grab
  - Insert balloon dilator past foreign body and inflate balloon

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LAPAROTOMY TIPS

- Either for patient compromise or failure to extract transanally despite adequate sedation
- Start with mini-laparotomy to apply pressure from above with assistant attempting to remove transanally
- If unsuccessful then colectomy with transabdominal removal proximally

IN CASE OF PERFORATION

- Can consider primary colon closure or resection and primary anastomosis if tissues of good quality and patient stable – same as for colon/rectum trauma
- Hartmann resection a reasonable option

Demetriades, Murray, Chan, et al, 2001 J Trauma

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POST EXTRICATION CARE

- Consider observation (hours) in order to detect missed perforation
- Consider endoscopic evaluation
- Consider CT evaluation if concerns
- Follow-up sphincter function
  - Refer to colorectal surgeon if sphincter dysfunction

Goldberg and Steele, 2010 Surg Clin North Am

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MANAGEMENT OF 'REPEAT OFFENDERS'

Those with multiple visits for foreign body ingestion/impaction:

- A multidisciplinary approach is key
- Review chart: what has been ingested before, why and what treatment was applied
- Strongly consider involvement of psychiatry team
  - >80% will have a psychiatric disorder
- Consider coexisting substance abuse and involve substance abuse team if available
- Avoid surgery if at all possible and instead try to rely on conservative or endoscopic measures

Palese and Al-Kawas, 2012 Gastroenterol Hepatol (NY)