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Review Article

Rectal Foreign Body in South Asia: A Systematic Review

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ABSTRACT

This systematic review aims to analyze patient demographics, insertion routes, intent, types of foreign bodies, clinical presentations, complications, and outcomes of rectal foreign bodies (RFBs) in South Asia, and to propose a management algorithm. A systematic review of case reports and case series was conducted following PRISMA 2020 (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. Inclusion criteria included case reports/series of RFBs from South Asian countries with the foreign body in situ or displaced to an adjacent organ. Exclusion criteria comprised non-English articles and unavailable full texts. PubMed and Google Scholar were searched on March 5, 2023, without date restrictions. Risk of bias was assessed using the JBI Critical Appraisal Checklist for Case Reports. Data were synthesized narratively, with descriptive statistics (means, SD, and frequencies) and chi-square tests for associations, using MS Excel and JASP 0.17.3.0. The review included 108 cases from 59 case reports/series, predominantly males (95 males, 11 females, 2 unspecified), with a mean age of 33.95 years (±15.09 SD). Transanal insertion (87 cases) was the most common route, followed by ingested (14 cases) and iatrogenic (7 cases) RFBs. Management involves imaging (X-rays/computed tomography), manual or endoscopic retrieval, and surgical intervention for complications like perforation (9.2%) or peritonitis (16.9%). Post-extraction sigmoidoscopy and psychological evaluation are crucial. The diversity of the foreign objects and variability in presentations require a high index of suspicion and a sensitive and structured clinical approach.

Key words: Rectal foreign body, South Asia, polyembolokoilamania, transanal, sexual gratification

INTRODUCTION

Rectal foreign bodies (RFBs) are an underreported yet clinically significant medical issue encountered globally. These cases present diagnostic, therapeutic, ethical, and occasionally medicolegal challenges for healthcare providers. Current literature indicates that RFBs are most commonly observed in middle-aged men, often associated with sexual stimulation. The most frequently retained objects include sexual devices, glass bottles, and food items. [1]

In South Asia, encompassing India, Nepal, Pakistan, Afghanistan, Bangladesh, Sri Lanka, Bhutan, and the Maldives, unique sociocultural and economic factors influence

RFB presentations. Limited access to healthcare, varying patient attitudes toward health-seeking behavior, and societal stigmas surrounding anorectal and sexual health issues contribute to distinct clinical patterns compared to global trends. Despite some reported cases from South Asia, comprehensive data on the epidemiology and clinical characteristics of RFBs in this region remain scarce.

This systematic review aims to address the gap in understanding RFBs in South Asia by analyzing patient demographics, insertion routes, intent, types of foreign bodies, clinical presentations, complications, and outcomes. Additionally, it proposes a management algorithm for RFBs based on existing literature.

METHODOLOGY

Literature Search

A systematic review, without meta-analysis, was carried out to study RFB in the context of South Asia following Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. [2] An extensive search on the PubMed and Google Scholar electronic databases was carried out on March 5, 2023, to identify case reports/series of South Asian patients, without restrictions on date. Two authors independently conducted a Literature search. The search strategy involved the following terms:

("Rectal Foreign Body" OR "Rectal Foreign Bodies" OR "Colorectal Foreign Body" OR "Colorectal Foreign Bodies")

AND ("Case Report" OR "Case Series")

AND ("South Asia" OR "Southern Asia" OR "Nepal" OR "India" OR "Pakistan" OR "Bangladesh" OR "Bhutan" OR "Afghanistan" OR "Sri Lanka" OR "Maldives").

Study Selection and Eligibility

Based on the literature search, two independent authors screened the studies, firstly the title and abstract, followed by a full text review.

Inclusion Criteria

1. Case series and case reports of RFB from southern Asia.
2. The foreign body is in situ or displaced to an adjacent organ during presentation.

Exclusion Criteria

3. All other types of study.
4. Articles published in languages other than English.
5. Full article not available.

Any disagreement between the two reviewers was resolved through consensus, and if necessary, was resolved by a senior author.

Data Extraction

Data were extracted using a templated spreadsheet in MS Excel and involved two authors. Conflicts at any stage of the study were resolved after discussion and agreement of the authors and, if necessary, were resolved by a senior author. The authors were not contacted to provide missing data. Due to incomplete data, results are reported based on the number of patients for whom specific variables were documented, rather than the total number of study participants. Outcome variables were clinical presentation, complication, morbidity, and intervention required. Other parameters included authors, journal, year of publication, age, sex, object, route, and intent of insertion.

Quality Assessment

For quality assessment, the JBI Critical Appraisal Checklist for Case Reports has been used. [3] Two authors independently performed quality assessment. No formal statistical methods were used to assess reporting bias.

Statistical Analysis

Data cleansing was performed in MS Excel, while data processing was performed in JASP 0.17.3.0. Data have been summarized using descriptive statistics, with means and standard deviations for continuous variables and frequencies and percentages for qualitative variables. Furthermore, the test of significance is assessed using the chi-square test.

Registration

The study has been registered in PROSPERO (CRD42024626334).

RESULTS

The PRISMA flowchart (**Figure 1**) illustrates that 178 articles were retrieved from the search. After removing duplicates and articles that did not meet the inclusion criteria, the systematic review analyzed 108 cases from 53 case reports and 6 case series. The study sample had a mean age of 33.95 years (SD ± 15.09). Within this demographic, there were 95 male individuals, 11 females, and 2 cases in which gender was not specified.

In particular, the transanal route emerged as the most prevalent method of insertion of a foreign body, accounting for 87 cases. Additionally, 14 instances involved the ingestion of foreign bodies, while 7 cases were attributed to iatrogenic origins.

Transanal Insertion of Foreign Body

In the context of transanal insertion of RFB, 34 incidents were attributed to sexual gratification, indicating a prevalent motive for this behavior. Assault accounted for 23 cases, while 10 cases were related to accidents. Amateur self-treatment was observed in 8 cases, suggesting a trend of people attempting to address medical issues, specifically hemorrhoids and constipation, without professional help. Treatment by traditional healers was reported in two cases (**Table 1**). Treatments for erectile dysfunction and abdominal discomfort were offered. Furthermore, in five cases where the cause was not specified, and in one case, the cause of insertion was not stated. Psychiatric illness and smuggling were each linked to two cases each.

The male-to-female ratio is approximately 20:1 in the sample. Instances of foreign body insertion for sexual gratification were exclusively observed in males. Similarly, cases involving

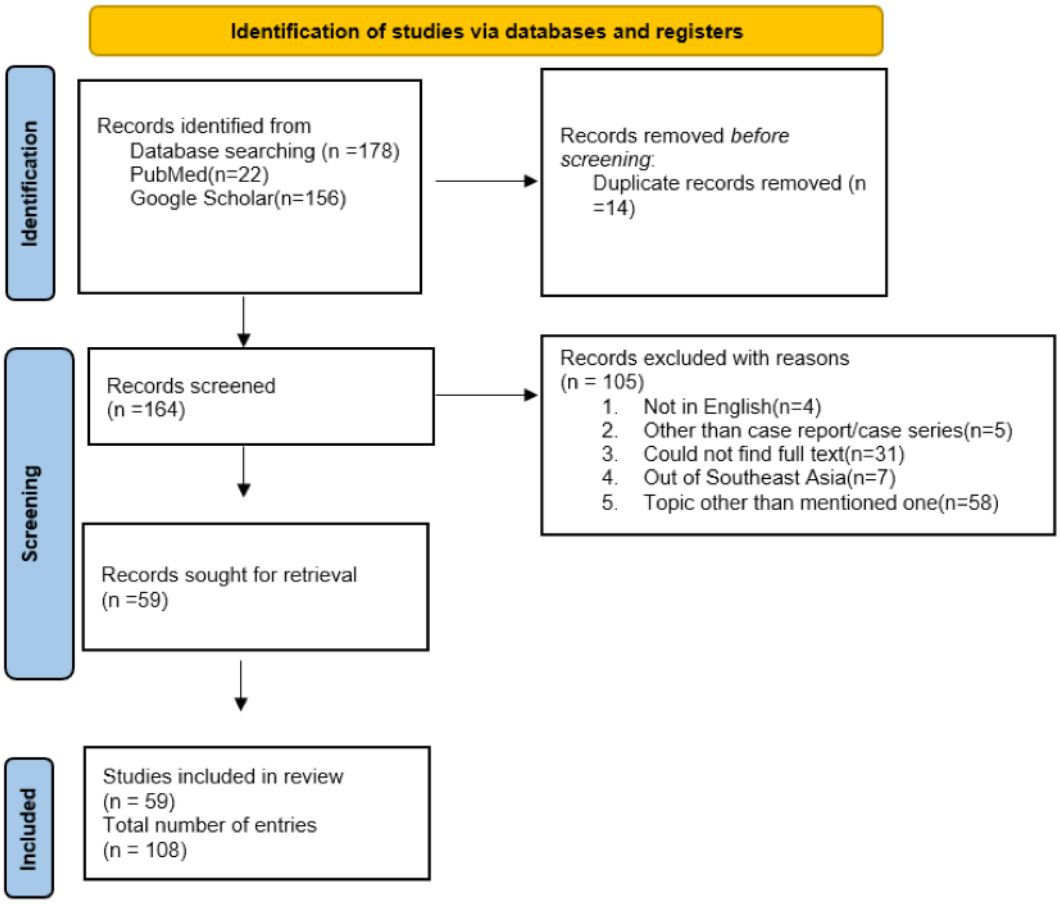

Figure 1: PRISMA flowchart showing the article selection process for the systematic review.

amateur self-treatment, treatment by traditional healers, situations where the cause was not specified in the article, or instances where patients did not provide information about the insertion, were also limited to males.

A diverse nature of foreign objects was obtained from the rectum, ranging from common household items like bottles and kitchenware to more unconventional items like horns and drug vials (**Table 1**). Among the cases, bottles were the most common foreign objects inserted, accounting for 22 instances. Metallic rods and various kitchenware items, such as tumblers, cups, and pestles, were each involved in eight cases. Wooden rods were inserted in six cases, while sanitary hardware items like shower bidets, water hoses, and top parts of water taps were identified in five cases. Interestingly, fruits and vegetables, metallic containers, and deodorant bottles were each found in five cases as well. Additionally, horns and toothbrushes were inserted in three cases and two cases, respectively, whereas drug vials, ampoules, and capsules were involved in three cases collectively. In one case, the patient inserted a glass bottle into the rectum for sexual gratification, which subsequently became lodged. In an attempt to remove the bottle, he introduced a metallic wire, which also became impacted, resulting in the presentation of two foreign bodies retained in situ.

The patients generally presented with a constellation of symptoms related to RFB insertions. The most common symptoms (n = 80) were abdominal pain (48.75%), difficulty in passing feces (26.25%), per rectal bleeding (25.00%), perianal pain (18.75%), lower abdominal pain (11.25%), and abdominal distention (11.25%). A minor proportion of patients (5%) showed no symptoms at presentation (**Table 2**). In pediatric cases, foreign bodies often cause injuries to nearby genitourinary structures, resulting in symptoms such as hematuria and dysuria.

A small fraction of patients presented with complications at the health-care center. Peritonitis was the most common complication, affecting 14 (16.9%) cases. Other complications included perforation (six cases, 9.20%), penetrating injury to the anal sphincter (one case, 1.15%), rectosigmoid gangrene (one case, 1.15%), and hemorrhagic shock (one case, 1.15%). In a pediatric case with accidental insertion, perforation occurred into the urinary bladder, leading to bladder entrapment and the formation of bladder stones after some time. One case reported a burst abdomen postoperatively.

A single case of mortality was reported among 87 cases, which was attributed to management without radiological guidance and anesthesia. Transanal extraction and laparotomy were the main modes of foreign body extraction (**Table 3**).

Ingested Bodies Retained in Rectum

In this study, a total of 14 cases were documented involving the ingestion of foreign objects that were subsequently

Table 1: Cause of rectal foreign body insertion and the object inserted.

Cause of foreign body insertion	Count
Sexual gratification	34
Accidental	10
Assault	
Sexual	11
Physical	4
Unspecified	8
Amateur self-treatment	8
Traditional healing treatments	2
Not specified	5
Not reported by the patient	1
Psychiatric illness	2
Smuggling	2
Total	**87**

Transanal object inserted	Count
Bottle	
Unspecified	12
Glass	8
Plastic	2
Metallic rod	8
Kitchenware (tumbler/cup/pestle)	6
Wooden rod	6
Sanitary hardware (Shower bidet/water hose/top of water tap)	5
Fruit/vegetable	5
Metallic container/deodorant bottle	5
Toothbrush	2
Horn	3
Drug vial/ampoule/capsule	3
Batteries	2
Pen/pencil	2
Cap of the bottle	2
Wooden splinter/incense stick	2
Others	15
Total	**88**

retained in the rectum. The study population had a mean age of 29.41 years (range 5–51 years), and a notable male-to-female ratio of 13:1 was observed among the cases. Betel nut emerged as the predominant foreign object found in the rectal cavity, with six cases recorded. Additionally, there were five cases involving the retention of bone pieces, and singular occurrences of retained coin, stone, and toothpick were documented (**Figure 2**).

Table 2: Presentation among transanal insertion of RFB (n = 80).

Symptoms	No. of cases	Percentage (%)
Abdominal pain	39	48.75
Difficulty in defecation/ constipation	21	26.25
Per-rectal bleed	20	25.00
Perianal pain	15	18.75
Lower abdominal pain	9	11.25
Abdominal distention	9	11.25
Vomiting	5	6.25
Retained foreign body	4	5.00
Dysuria	2	2.50
Difficulty walking	1	1.25
Hematuria	1	1.25
Diarrhea	1	1.25

Similar to cases involving RFBs through the transanal route, individuals in this study also present with multiple symptoms. The prevalent symptom among these patients was abdominal pain, reported by 57% of the cases. Other frequently observed complaints included perianal pain (35%), per rectal bleeding (21%), difficulty in passing feces (21%), and abdominal distention (14%; **Figure 3**). These symptoms collectively underscore the varied clinical presentations associated with RFBs in the South Asian population. Complications were relatively uncommon in this population; however, one case, involving a retained toothpick, progressed to peritonitis.

Most of the cases of ingested RFB underwent dilation and transanal extraction: six of the cases were performed under GA, while a single case was performed under spinal anesthesia. Six of the cases involved laparotomy, and a single case involved rectal enema administration for foreign body extraction (**Figure 4**).

The chi-square test indicated a significant association between complications at presentation and the need for laparotomy for foreign body extraction ($\chi^2 = 18.949$, $P < 0.001$), suggesting a strong correlation between these factors. However, no significant correlation was observed between laparotomy and extreme age groups (<10 and >60 years) ($\chi^2 = 0.898$, $P = 0.343$) or the route of foreign body insertion. Notably, among patients who inserted foreign bodies transanally, a significant correlation with laparotomy was found in those with the intent of sexual gratification ($\chi^2 = 17.587$, $P < 0.001$) and in cases of assault ($\chi^2 = 8.517$, $P = 0.004$), whereas no such correlation was observed in cases of accidental insertion ($\chi^2 = 1.215$, $P = 0.270$).

Iatrogenic Origin of RFB

A small fraction of patients presented because an object, placed during the course of treatment, migrated and became embedded in the rectal tissue. Seven such cases were reported, out of which three were attributed to Polypropylene Mesh placed for mesh rectopexy, two cases were due to

Table 3: Management in patients with transanal insertion of RFB.

Transanal extraction	Under GA	16
	Under spinal anesthesia	9
	Under analgesia	2
	Unspecified	2
	Under sedation	1
	Without radiological guidance and anesthesia	1
Laparotomy	Unspecified	21
	Colostomy	10
	With colotomy	8
	Transanal	5
	With colon resection	3
	Transanal extraction with colostomy	1
Unconventional	Transanal with a Foley's catheter	1
	Suprapubic cystotomy	1
	Cystolithotomy	1
	Hartmann with colostomy	1
Extracted by defecation	Extracted by defecation	2
Unspecified	Unspecified	2
Total		**87**

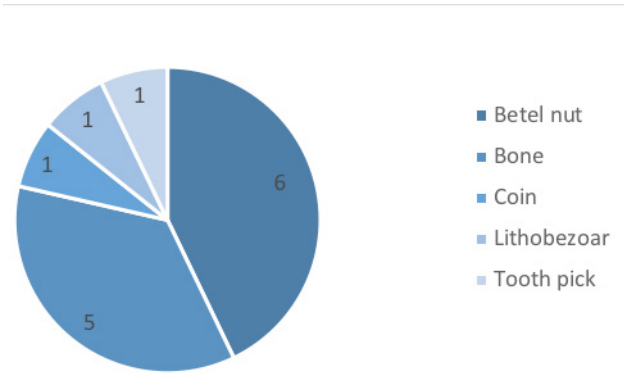

Figure 2: Ingested object retained in rectum.

intrauterine device (IUCD) migration, and two were due to gossypiboma (a foreign object, such as a mass of cotton matrix or a sponge, that is left behind in a body cavity during surgery), which later embedded in the rectal wall. The mean age of the population was 42.14 years (range 30–56 years), and the male-to-female ratio was 1:6.

Most of the patients presented with abdominal pain (three cases, 42.86%) and were unable to defecate (three cases, 42.86%). Diarrhea (two cases), perirectal bleed (two cases), and abdominal distension (one case) were other symptoms seen (**Figure 5**). Unable to pass feces was seen exclusively in cases with displaced polypropylene mesh, and diarrhea was exclusive in cases with a surgical swab in the rectal mucosa. One of the cases with a migrated IUCD presented with peritonitis.

Among three of the cases with migrated polypropylene mesh into the rectum, two of the cases underwent anterior resection of the rectum with stapled end-to-end anastomosis, while one of them had transanal removal of mesh. In two cases with a surgical swab embedded in the rectal wall, laparotomy with Hartmann procedure was performed in one case, while in the other case, some surgical management was done, which was not elaborated in the article. For IUCD migration into the rectum, laparotomy with extraction of the foreign body and endoscopic mucosotomy were performed, respectively.

DISCUSSION

In this study, we examined 108 cases of RFBs, with 87 cases resulting from transanal insertion, 14 cases involving retained foreign bodies, and 7 cases due to iatrogenic causes.

RFB presentation, though relatively uncommon, has been on the rise in recent years. [4] While cases have been documented across all age groups and genders, research consistently highlights a disproportionately higher prevalence among male patients, particularly those in their 30s and 40s. [1, 4–9]Our analysis revealed a striking male-to-female ratio of approximately 20:1, with a mean patient age of 33.95 years (SD ± 15.09).

The leading cause of RFB in our study was transanal insertion for sexual gratification, accounting for 31.5% of cases, a

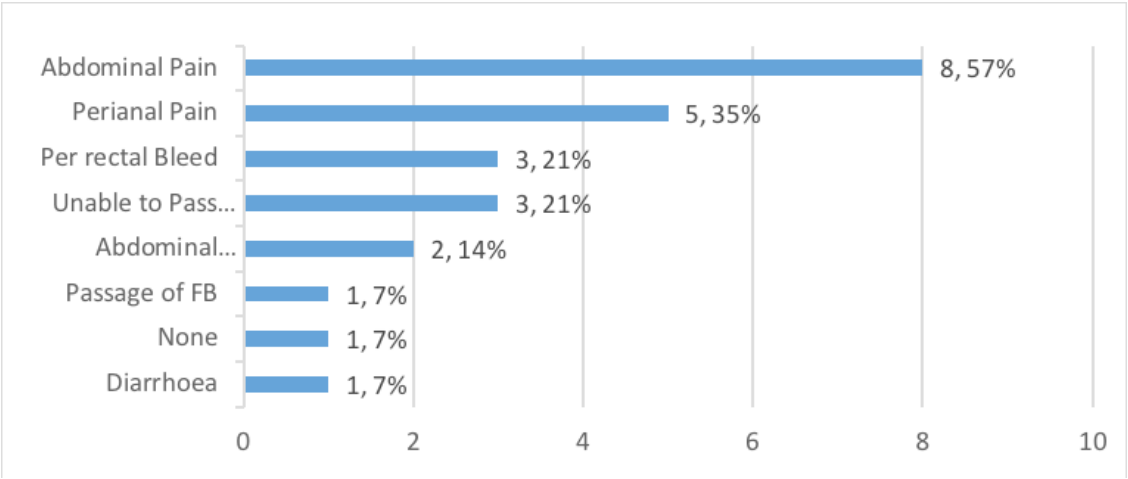

Figure 3: Presentation of cases with foreign bodies retained in the rectum.

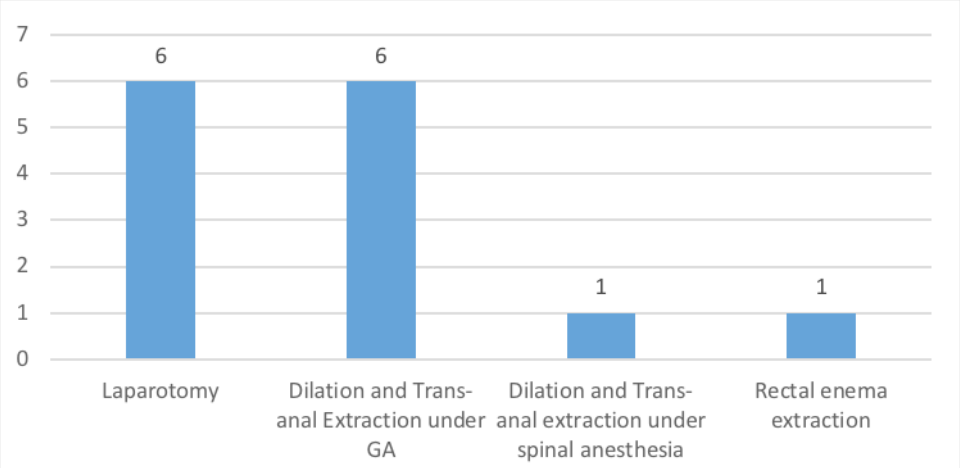

Figure 4: Management of cases with an object retained in the rectum.

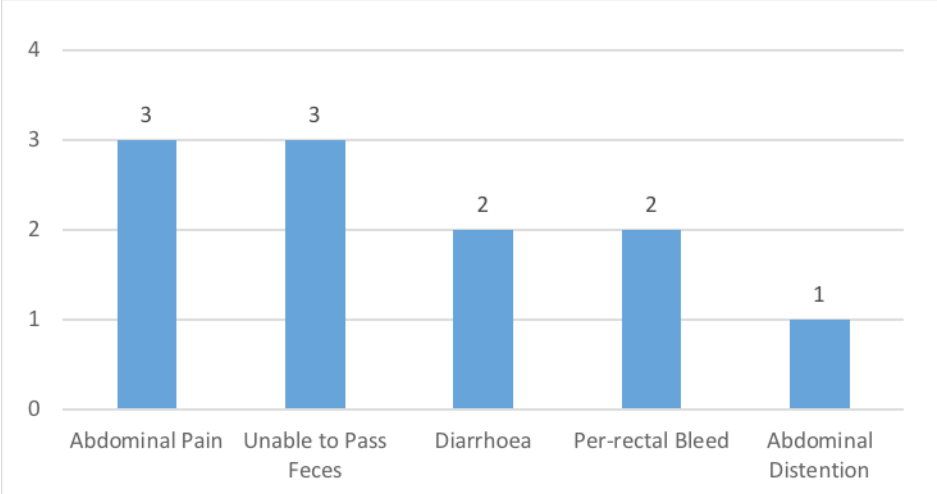

Figure 5: Symptoms of patients with rectal foreign bodies of iatrogenic origin.

finding consistent with existing literature. [1, 4–6, 8, 10]This behavior is believed to be associated with the anatomical presence of the prostate gland, located between the bladder and penis, which is accessible via the rectum and contributes to sexual satisfaction during stimulation. [10] Psychiatric comorbidities, including perversion disorders, depression, and personality disorders, were commonly observed among these patients. Other causes included sexual assault (21.3%), accidental insertion (9.3%), amateur self-treatment (7.4%), treatment by traditional healers (1.9%), smuggling (1.9%), and unspecified causes (4.6%). Retention of ingested objects was noted in 13.0% of cases, while iatrogenic causes—such as IUCD migration, displaced polypropylene mesh, and retained surgical swabs—comprised 6.5%. Notably, 85.7% of iatrogenic cases occurred in female patients.

Interestingly, two cases involved patients who reported inserting foreign bodies with the intention of relieving hemorrhoidal symptoms, although no clinical evidence of hemorrhoids was found upon examination. This finding raises the possibility that a significant proportion of RFB insertions may be driven by sexual paraphilic behavior, which could be more prevalent than currently recognized. While sexual gratification has been consistently identified as the most common underlying motive for such insertions in the literature, the actual prevalence may be substantially underestimated. This underreporting is likely influenced by the associated stigma, shame, and cultural sensitivities surrounding sexual practices, particularly within the South Asian context. These insights highlight the importance of adopting a non-judgmental and culturally sensitive approach in the clinical management of patients presenting with RFBs, to ensure accurate reporting and compassionate care.

Previous studies have broadly classified RFBs into voluntary and involuntary categories. Voluntary insertions typically occur for purposes such as sexual gratification or smuggling, whereas involuntary cases may arise from sexual assault, accidental ingestion, or iatrogenic causes. [9] Patients with voluntarily inserted objects often delay seeking medical attention, usually after several failed self-extraction attempts. [8, 11, 12] Body packing cases, in particular, pose significant

clinical challenges due to the risk of complications such as impaction, intestinal obstruction, perforation, and rupture of drug-containing packets. Rupture can result in systemic absorption of toxic substances and may also occur during attempts at removal, further complicating management. Consequently, all cases involving retained foreign bodies should be approached as potentially hazardous. [9] Involuntary insertions are more frequently observed in vulnerable groups, including children, elderly individuals, females, and those with psychiatric disorders. [9] In cases related to sexual assault, it is crucial to address not only the clinical aspects but also the psychological impact on the patient and the medico-legal obligations involved. [4, 9]

Although in the western part of the world, the commonest RFBs include sex vibrators and dildos, a variety of objects were retrieved in our study. [4] Bottles were the most common (20.4%), followed by metallic rods and kitchenware (7.4% each), wooden rods (5.6%), sanitary hardware such as water hoses and taps (4.6%), and fruits, vegetables, deodorant bottles, and drug containers (4.6% each). The choice of object was typically influenced by its accessibility and the underlying motivation for insertion. One particularly complex case involved a patient who, after inserting a glass bottle, introduced a metal wire to remove it, leading to dual impaction. These findings indicate the impulsive nature of some insertions and emphasize the importance of public education regarding the potential hazards.

Betel nuts (5.6%) and bone pieces (4.6%) were the most common ingested items, alongside individual cases involving coins, stones, and toothpicks.

Several factors can complicate retrieval: smooth surfaces make grasping difficult, friable or unyielding objects may break, and sharp objects can cause injuries to both patient and healthcare provider. [9, 11] And very large objects may become impacted by the pelvic floor muscles. [13]

Clinical presentation varied: The most common symptom was abdominal pain (48.75%), followed by difficulty in defecation (26.25%), rectal bleeding (25.00%), perianal pain (18.75%), lower abdominal pain (11.25%), and abdominal distension (11.25%). A minority of patients (5%) were asymptomatic. In pediatric cases, genitourinary symptoms such as hematuria and dysuria were frequently observed. Complications included peritonitis (16.9%), rectosigmoid perforation (9.2%), and rare instances of anal sphincter injury, rectosigmoid gangrene, hemorrhagic shock, and postoperative burst abdomen (1.15% each). A single case of mortality (0.9%) in our study was attributed to blind extraction without anesthesia or radiological guidance. This highlights the importance of proper imaging and anesthesia planning to prevent fatal complications.

Delayed presentations are common due to embarrassment or failed self-retrieval attempts. [8, 11, 12] Plain radiographs, water-soluble contrast enemas, and computed tomography (CT) scans are crucial for localization and identifying complications. Gas under the diaphragm on an erect chest X-ray indicates perforation. [5, 8, 9, 12] Laboratory investigations are useful in detecting infection or sepsis. [5, 9] The management of RFBs requires a systematic and individualized approach guided by clinical presentation and potential complications. Initial evaluation includes a detailed physical examination and appropriate imaging modalities such as abdominal and pelvic X-rays, water-soluble contrast enemas, or CT scans, especially in cases where complications like bowel perforation are suspected. If signs of perforation or peritonitis are present, immediate resuscitation followed by surgical intervention is warranted. Perforation mandates urgent laparotomy. [4–6, 9, 11, 13–15] Early and small perforations may be repaired primarily, while large or delayed ones often require diversion. [9] In complex cases involving large, impacted objects, colotomy with or without stoma creation may be necessary. [16]

In the absence of perforation, digital rectal examination is essential for the localization of foreign bodies and for the assessment of rectal injuries, bleeding, discharge, and sphincter tone (**Figure 6**). [1, 5, 8, 9] However, caution should be taken considering the nature of objects, as a sharp object can prick the examining doctor.

The location of the object determines subsequent steps. Eftaiha classified RFBs into low-lying (palpable in the rectal ampulla) and high-lying (at or above the rectosigmoid junction). [17] Small, non-sharp objects may pass with enemas or laxatives, although care must be taken to avoid mucosal damage or impaction. [18] If unsuccessful, low-lying objects may be manually removed under sedation or spinal anesthesia. Tools for extraction include Kocher clamps, ring forceps, [9] obstetric forceps, [19, 20] vulsellum, [21] myomectomy screws, [22] ventouse extractors, [23] tonsil snares, [24] sponge forceps [25], and bone-holding clamps. [26] Smooth objects that form a vacuum seal with the rectal mucosa may require the use of a Foley catheter to break the seal. [9] Obstetric vacuum extractors may also assist in canal widening and safe removal. [9, 23] Sharp objects should be removed under direct endoscopic visualization. [9]

High-lying objects, situated at or above the rectosigmoid junction, may necessitate endoscopic retrieval or manipulation to reposition the object for trans anal removal. Some authors suggest gently milking smooth objects toward the rectum to facilitate removal. [1, 9, 27]Surgical intervention via laparoscopy or laparotomy is considered when non-invasive techniques fail, particularly for large or impacted objects, with colostomy and stoma formation reserved for the most complex cases.

Following extraction, the rectal mucosa should be carefully inspected for injuries, and sphincter function assessed to detect possible fecal incontinence. [14] Post-procedure sigmoidoscopy is advised to rule out perforation or residual mucosal damage. [16] Psychological evaluation and counseling are imperative to address underlying behavioral or psychiatric issues, reduce recurrence risk, and promote safer alternatives. [9]

This study on RFBs has several limitations that warrant consideration. The study relies on data from case reports and series, which often include unconventional or atypical cases, limiting its generalizability to real-world scenarios. Furthermore, the retrospective design inherently restricts the ability to establish causality and relies on the accuracy and completeness of medical records, which may introduce bias

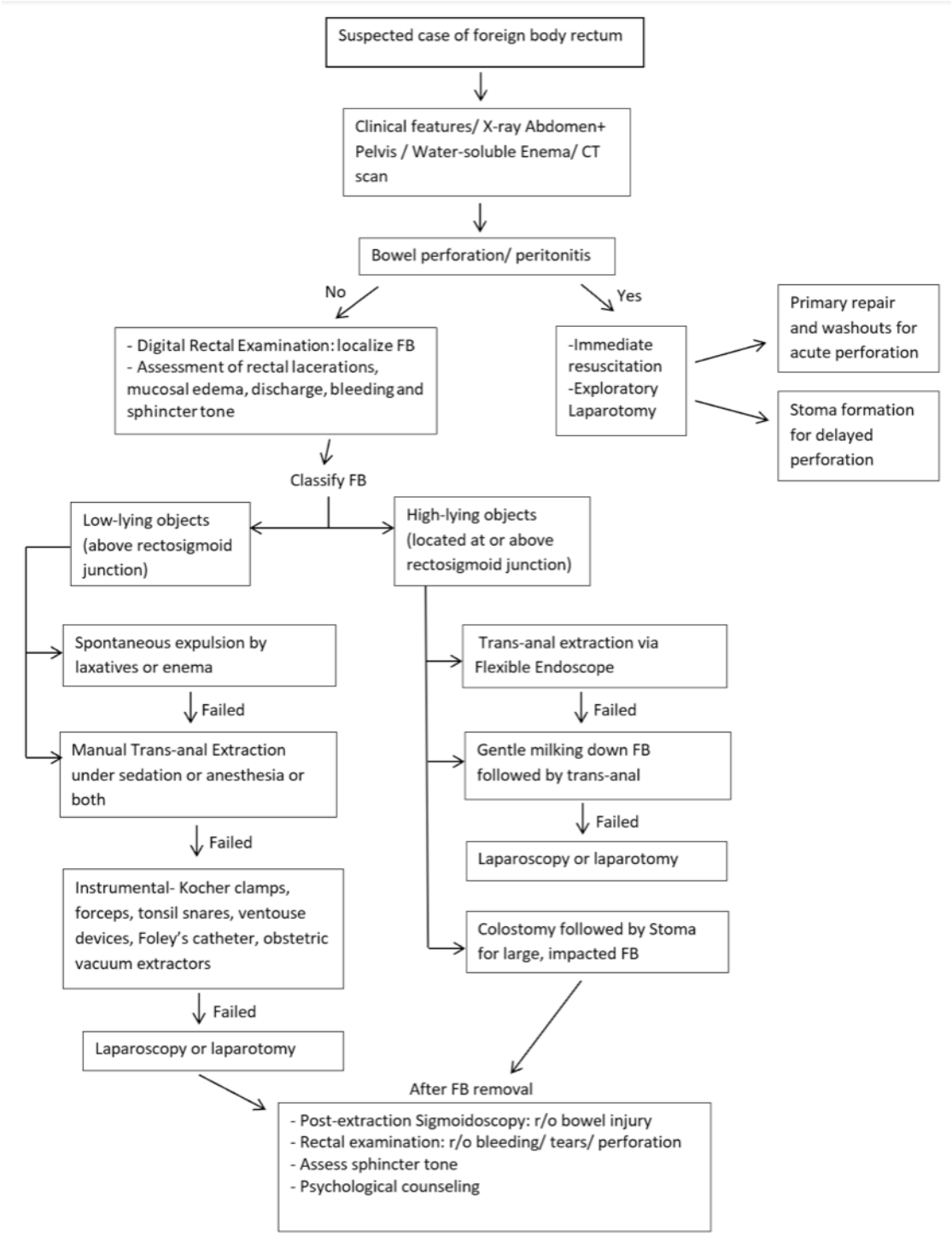

Figure 6: Management algorithm for rectal foreign body.

or missing data, particularly regarding unspecified causes of insertion or incomplete patient histories. Besides, the absence of long-term follow-up data restricts insights into recurrence rates, long-term complications, or psychological outcomes post-intervention. Finally, the reliance on specific imaging and extraction techniques may not reflect practices in resource-limited settings, potentially limiting the applicability of findings to diverse healthcare environments.

CONCLUSIONS

This systematic review highlights the wide clinical spectrum and sociocultural complexity that surrounds RFBs in the South Asian region. The diversity of the foreign objects and variability in presentations require a high index of suspicion and a sensitive and structured clinical approach. Emphasis on proper diagnostic protocols, prompt management, and post-extraction evaluation, including psychological support, is

essential to improve results. A culturally aware, nonjudgmental healthcare environment is critical to ensure early reporting, reduce complications, and prevent recurrence.

AUTHORS' CONTRIBUTION

All authors have significantly contributed to the work, whether by conducting literature searches, drafting, revising, or critically reviewing the article. They have given their final approval of the version to be published, have agreed with the journal to which the article has been submitted, and agree to be accountable for all aspects of the work.

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CONFLICT OF INTEREST

None.

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