Rwanda Medical Journal RMJ

CASE REPORT Open Access

Management of Rectal Foreign Body Impaction in a Female Patient: A Case Report Highlighting Challenges in an African Community Setting: A Case Report

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ABSTRACT

Rectal Foreign Body impaction is an emergency condition that requires prompt evaluation and management. However, in African countries, discussing issues related to sexual health, especially anal intercourse or self-stimulation, is often considered a taboo. Many individuals avoid seeking medical attention due to fear of judgment, shame, or religious beliefs. This case report presents a 21-year-old female from Rwanda who was presented with an impacted foreign body following a sexual self-stimulation with a perfume bottle. The report explores the medical, psychological, culture and religious considerations involved in such cases.

Keywords: Anal foreign body, sexual act, anal foreign body impaction

INTRODUCTION

In Rectal foreign bodies are increasingly becoming a common presentation in the Emergency Department [1]. Generally, in Africa, rectal foreign bodies are rarely reported or presented at hospitals, mainly due to several reasons, including sexual pressure or accidental causes. Cultural sensitivities can easily intimidate victims with feelings of embarrassment, fear, and stigma [2]. This often leads to delays in seeking medical consultation and treatment. These patients initially present at the emergency department, so it's essential for emergency physicians to handle these cases with care and in a systematic way. Their history is often unclear, and inconsistent. This highlights the importance of comprehensive history-taking and thorough physical examination conducted promptly in the emergency setting [3]. Following initial assessment and diagnosis, the most challenging aspect is devising a suitable treatment plan, which typically requires multidisciplinary collaboration among emergency physicians, surgeons, gastroenterologists and radiologists [1,3].

CASE PRESENTATION

A 21-year-old female, presented to a tertiary-level hospital emergency department with complaints

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Received: 14th February 2026; **Initial decision given:** 16th February 2026; **Revised manuscript received:** 26th April 2026; **Accepted:** 6th June 2026.
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Citation for this article: Zeinab Said Hassan; Yohannes Feleke; Christian Niyonzima et al. The role of emergency care systems in health systems strengthening: the Africa Health Sciences University model. Rwanda Medical Journal, Vol. 83, SI, p. 9-12, June 2026. https://dx.doi.org/10.4314/rmj.v83i2.11s

of severe lower abdominal pain, and rectal discomfort. The patient had no nausea, vomiting nor abdominal distention. She was initially hesitant to disclose the nature of her condition to the family due to fear of judgment and religious beliefs regarding sexual purity. However, after reassurance from the medical team, she admitted that she had experimented with anal penetration using a perfume bottle. She attempted self-removal, which was unsuccessful, and sought medical attention after 36 hours.

When the patient presented at King Faisal Hospital in Rwanda, her blood pressure was 108/66 mmHg, her heart rate was 75 beats per minute, and her oxygen saturation was 98% on room air. She could walk and sit on her own. The abdominal exam showed mild tenderness in the suprapubic area, but no signs of peritoneal irritation. The perianal exam revealed no external bleeding or trauma. A preliminary digital rectal exam showed decreased anal sphincter tone, indicating possible sphincter weakness. It also detected a hard object about 7-9 cm deep from the anal opening.

The plain abdomino-pelvic X-ray revealed a tubular, radiolucent cylindrical structure within the rectum, featuring a well-defined round metallic density at its proximal end, indicating a foreign body (Figure 1). There is no sign of bowel obstruction: the bowel gas pattern is normal, with no significant colonic dilation, and no free intraperitoneal air is present. The bony pelvis looks intact, without any acute fractures or dislocations. Impression: A rectal foreign body with a characteristic cylindrical shape and metallic cap, showing no radiographic signs of obstruction or perforation.

After completing the preoperative investigation, which showed normal results, the emergency team called in the gastroenterologist and surgical team for a multidisciplinary approach. The patient was then transferred to the operating room for removal of a rectal foreign body using colonoscopy under sedation. Sedation was achieved through intravenous administration of 50 mg of Propofol and 50 mg of Ketamine. An adult colonoscope was then inserted to assess the condition of the rectal mucosa, determine the size and diameter of the foreign body, and locate its position relative to the anal verge.

Endoscopic visualization revealed an intact rectal mucosa without evidence of injury. A body spray container with a height (length) of approximately 12 to 15 cm and a diameter of around 4 to 5 cm (Figure 2) was visualized approximately 15 cm from the anal verge.

The container under direct visualization was carefully mobilized and guided down to the lower rectum using an endoscopic snare. A GI team assistant grasped the distal portion of the object employing a three-finger grip technique, and smoothly extracted it from the anal canal. The procedure was completed without any immediate complications such as bleeding, perforation, or post-procedural discomfort. The patient was discharged after an overnight stay with pain relief and stool softeners to ease bowel movements and minimize straining. Upon discharge, the patient was counseled and instructed on performing Kegel exercises to help restore anal sphincter tone with a follow-up appointment to the GI outpatient clinic to reassess sphincter function and monitor for any delayed complication. The medical team reassured her that her case was handled with confidentiality and encouraged her to seek accurate sexual health education and psychotherapy. The patient asked for psychosocial support, which includes confidentiality and psychotherapy sessions, and was referred to those services.

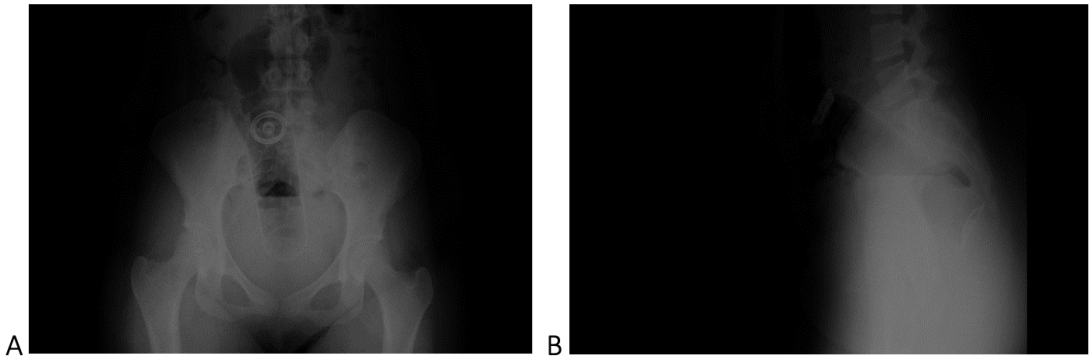

Figure 1: Plain abdomino-pelvic X-ray (A) and (B) Pelvic X-ray in anteroposterior and lateral views showing a foreign body

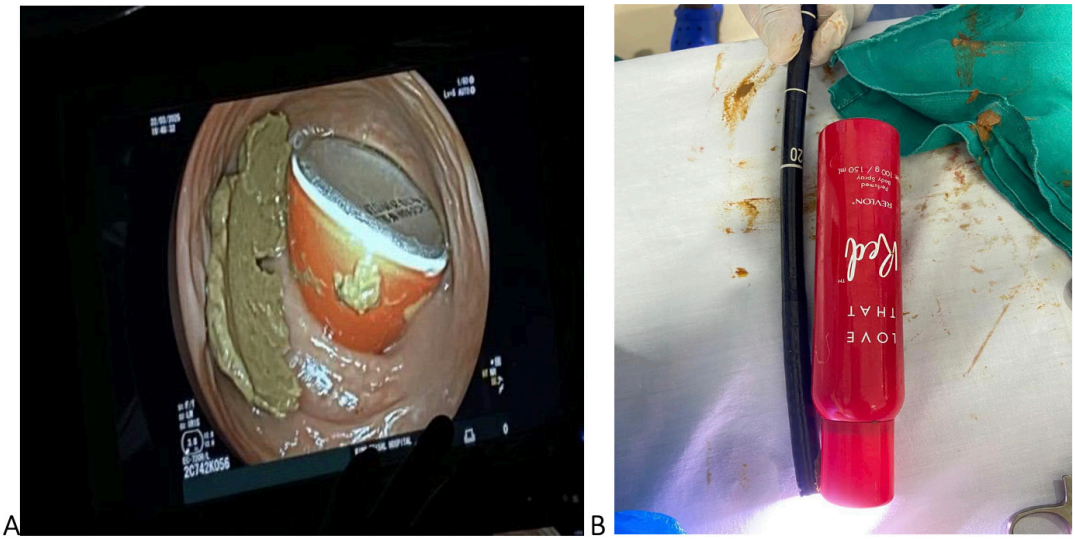

Figure 2: Endoscopic visualization of the impacted body spray container within the rectum and (B) the same retrieved container following endoscopic-assisted transanal removal.

DISCUSSION

In many African communities, subjects related to sexuality particularly anal intercourse, masturbation, and the use of objects during sexual activities remain highly taboo or are deemed sinful due to dominant cultural and religious norms [2,3]. This pervasive stigma restricts open dialogues on sexual health and often deters affected individuals from seeking timely medical care, thereby escalating risks for severe complications such as rectal perforation, sepsis, and fistula formation [4]. This contrasts with some developed countries where cases involving sexual foreign bodies have been more openly reported and managed with diverse approaches [5].

The types of foreign bodies inserted, literature reveals a wide variety, ranging from household items (bottles, bulbs, vegetables) to sexual devices. The motives for insertion vary widely and include sexual gratification, curiosity, concealment, or even psychiatric disorders [2]. Clinical presentations often include symptoms such as pain, bleeding, discharge, and, in advanced cases, systemic infection signs if complications like perforation occur [6]. Extraction techniques are dictated by the object's nature, size, location, and complications present. Minimally invasive methods such as endoscopic retrieval or manual extraction under anesthesia are preferred to avoid further injury. In complicated cases involving perforation or abscesses, surgical intervention may be necessary. Prompt intervention minimizes morbidity and prevents long-term sequelae [7].

Complications from retained foreign bodies are significant and include rectal mucosal trauma, perforation, local infections, sepsis, fistula formation, and in rare cases, fatal outcomes. Psychological impacts such as shame or post-traumatic stress disorder are also notable, especially in environments where sexual taboos are strong [4].

CONCLUSION

This case highlights the unique challenges faced by patients in Africa who experience anal or elsewhere foreign body impaction. Healthcare providers should approach such cases with cultural sensitivity, confidentiality, and a balance of medical and psychosocial support. By promoting nonjudgmental medical care and respectful education on safe sexual practices, clinicians can help prevent complications while respecting patients' culture and beliefs.

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