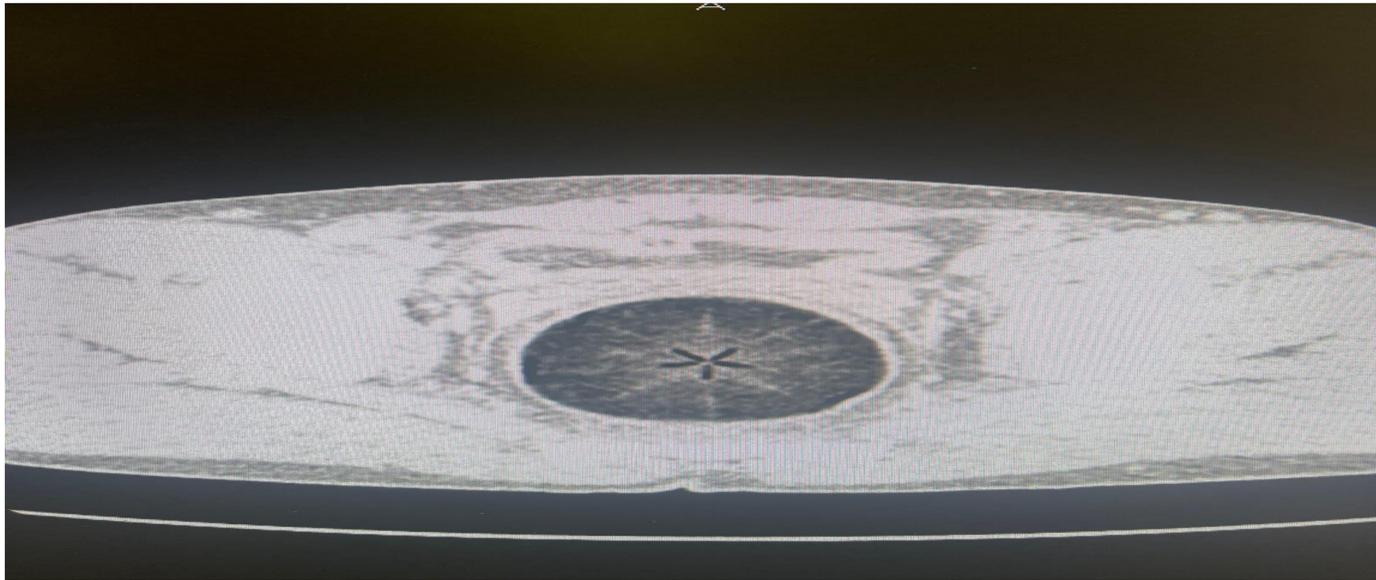


Case Report: “I Can’t Pee”

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CASE

A 33-year-old male with no prior medical history presented to the emergency department (ED) with complaints of urinary retention and constipation. The patient stated he was unable to urinate or have a bowel movement for one day and reported moderate discomfort. He reported drinking a significant amount of fluid without improvement of his symptoms. Vital signs were stable on evaluation. The patient appeared acutely ill and was noted to have a diffusely tender abdomen on exam. A Foley catheter was put in place but did not have drainage. Abdominal X-ray taken while waiting for advanced imaging showed unusual non-specific air space density. Computed tomography (CT) of the abdomen was performed.

CT demonstrated a rectal foreign body resembling fruit. The patient was then asked if he placed any foreign body into his rectum. Although reluctant, he eventually confirmed that he inserted an apple into his rectum and that he was unable to retrieve it. Multiple attempts at manual removal by the surgical team were unsuccessful in the ED. He was then taken to the operating room for surgical removal. The apple was successfully removed via dissection into small pieces. After the surgery the patient’s Foley began draining urine and was later removed. The patient left against medical advice the next morning after his procedure.

DISCUSSION

This case highlights the importance of a detailed history and physical examination and the importance of the doctor-patient relationship. Acute urinary retention has a large differential, which requires diligence and patience to evaluate. The patient, after initial Foley placement drained no urine; his abdominal X-ray demonstrated a non-specific air density, which led to CT imaging. Rectal foreign bodies are often placed for pleasure but can be signs of abuse or dangerous sexual behaviors that ED physicians need to address

DISCUSSION (continued)

This type of subject necessitates that the ED physician develops a rapport with the patient and makes the patient feel comfortable enough to share personal details that they may be reluctant to share.

Multiple methods have been used in the ED for removal of rectal foreign bodies. The approach depends on the size and shape of the object. Less invasive measures are attempted first. Often sedation can be used to facilitate manual removal. Perianal blocks with local anesthesia can also be tried. Various attempts at patient positioning can also be successful, such as lithotomy position can be successful in combination with suprapubic pressure, Valsalva maneuver, direct rectal examination. Placing the patient in a knee to chest position may also work. Anoscopy and obstetric forceps can be used to facilitate visualization and retrieval. It is particularly difficult to retrieve large bulbar objects due to a suction effect. This type of object can be removed by introducing multiple foley catheters beyond the object and slowly retracting the inflated Foleys. When these less invasive measures fail, or if the objects are sharp, due to risk of ischemia or perforation operative removal is indicated. In our case, these measures were unsuccessful, and the patient was taken to the OR for definitive removal.

CLINICAL PEARLS

- Multiple causes of acute urinary retention exist. A large rectal foreign body should be on the differential.
- Rectal foreign bodies are often placed for pleasure but can be signs of abuse or dangerous sexual behaviors that ED physicians need to address. Investigate gently and develop rapport with the patient to encourage them to share these relevant details.
- Multiple methods exist for removal for rectal foreign bodies including placement of Foleys past the obstructing foreign body and pulling to sedation and manual exploration. Operative intervention is indicated for sharp foreign bodies or perforation, large foreign bodies, or after multiple failed attempts.