Laparoscopic repair of rectal foreign body perforation without protective colostomy (with video)

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Surgical management of colorectal perforations is typically performed via laparotomy. However, a laparoscopic approach has been successfully applied in the treatment of colonoscopic perforations, and equivalent operative outcomes as open procedures can be accomplished in selected patients [1].

There are also some reports in the literature of laparoscopic closure of rectal perforation without protective colostomy in case of incidental rectal injury during prostatectomy or radical cystectomy [2].

A laparoscopic repair of a colorectal perforation secondary to transanal foreign body insertion was first described by Arora et al. [3], but a diverting colostomy was associated to the procedure.

In this video (Video S1), a laparoscopic primary repair of an upper rectal foreign body perforation without colostomy was performed, 12 hours after the incident.

A 30-year-old man presented to the emergency department with severe lower abdominal pain associated with rectal bleeding following transanal insertion and removal of dildo, twelve hours earlier. Clinical examination revealed obvious signs of generalized peritonitis and CT-scan showed pneumoperitoneum.

The patient was informed about the treatment options: laparoscopy, perforation closure combined or not with a diverting colostomy according to surgical exploration findings, and the possibility of conversion to laparotomy.

At laparoscopy, a large transverse tear in the anterior upper and intraperitoneal rectal wall was identified. The banks of the perforation, which were approximately 5 cm long, were not necrotic. There was no gross faecal contamination of the peritoneal cavity.

After lavage of the peritoneal cavity with isotonic saline solution, the rectal lesion was closed with absorbable interrupted sutures. No protective colostomy was performed.

The patient made an uneventful recovery and was discharged 4 days later. This video shows the different steps of this surgical procedure and could be potentially usefull for all surgeons participating to management of surgical emergencies (Fig. 1).

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Figure 1. The rectal lesion was closed with absorbable interrupted sutures.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.jviscsurg.2014.09.009.

References