Fish Bone Dislodged from the Throat Stuck in the Rectum: Case report

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Introduction

Many people have the experience in life having a fishbone stuck in his throat. It is something that happens when fish or meat is ingested that still have some of its smaller bones are present in it. When this happens, usually we have to wait for the bone to dislodge itself or we eat or drink other things, to dislodge or remove it from the throat. In some cases people might go to the doctor to remove it. After removal from the throat it passes through the GIT and mostly removed from the body with stool. But in some cases it may stick once again at any part of the GIT especially if the bone has multiple spikes [1]. There are multiple case reports describing perforation and penetration of various internal organs and rectum by fish bone [2, 3].

Case Report

A 52-years-old male medical personnel presented to the surgical outpatient clinic of Al- Ansar Hospital, Madinah, Saudi Arabia with a complaint of severe stabbing anal pain of three hours duration. He informed that 6 days back a fishbone stuck in his throat while he ingested fish in his lunch. He felt severe pain and spasm in the throat.

Immediately after that he swallowed few soft and sticky rice balls and had a glass of water as well. He felt that the bone has dislodged after few minutes and it caused relief of pain and spasm in the throat. Three days later he felt severe pain in the umbilical region for 2-3 hours and eventually the pain got relieved without any medication. On the sixth day after a defecation he started to feel stabbing pain in the anal region and rushed to emergency department of the hospital. He was very anxious and distressed.

The surgical consultant felt some pointed foreign body by per rectal examination (PR) and tried to remove manually with the patient at different positions. This approach failed.

Nothing was visible by proctoscopy. An X-ray of the lower

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abdomen and pelvis was done but revealed nothing abnormal clearly but a suspicion of foreign body near the shadow of the coccyx. As the patient complained of severe pain, the surgeon sent him to gastro-enterology department for sigmoidoscopy. In sigmoidoscopy, however, revealed a piece of bone lying transversely across the rectum just above the anorectal junction; two ends of the bone were embedded in the wall (Figure 1). No abnormality was found on general physical examination and routine lab investigations of the patient.

**Figure 1.** Fish bone embedded in the anal wall.

**Discussion**

Accidental fish bone swallowing is a common occurrence as fish is a regular part of human meal, bone ingestion turned out to be an inevitable associated risk on the daily eating activities [4]. Goh et.al revealed that fish bone was the commonest type of foreign body (FB) ingested [5]. Most ingested foreign bodies pass through the GIT uneventfully within 1 week; however, owing to the bone sharpness, it may potentially cause penetration or perforation of GIT and vital internal organs. The patient felt pain in the umbilical region on the 4th day which could be due to the sticking of the bone in the GIT wall, especially, in the ileocecal junction. After that it might had a successful and harmless passage in the GIT and again lodged and stuck just above the anorectal junction. Usually, foreign bodies become lodged in the mid rectum, where they cannot negotiate the anterior angulations of the rectum. They can be lifted on digital examination. With adequate sedation, the rectal FBs can be extracted by digital palpation, with endoscopy, in an emergency department or operation theatre under direct vision [6]. If the foreign object is palpable and can be visualized; a local anesthetic agent is given by subcutaneous and submucosal injections of 0.5% lidocaine. The anus can be dilated with a rectal retractor and the foreign body grasped and removed. Removal of a rectal foreign body may be of high risk and should be done by a surgeon or gastroenterologist skilled in foreign body removal. Abdominal examination and chest X-rays may be necessary to exclude possible intraperitoneal rectal perforation. Sigmoidoscopy is required following extraction to evaluate mucosal injury or perforation [7]. Operative intervention is needed in minority of the patients who developed signs of perforations, peritonitis, bleeding, obstruction, and pelvic sepsis [6]. Possible intervention could include a proctoscopy, sigmoidoscopy retrieval of rectal FBs, or laparotomy with subsequent stoma, closure of perforation or Hartman’s procedure. The reported patient was fully aware of the presence of the fish bone on his GIT but due to absence of any serious symptoms, it was just ignored until the appearance of pain in the anal region on the 6th day. A detailed clinical history and physical examination are essential for the diagnosis and management of any lesions [8]. Acute peritonitis is frequently caused by perforation and presented as a sudden, severe abdominal pain due to sharp FBs. High fever
develops rapidly with nausea, vomiting and paralytic ileus. As the bacterial infection may spread to affect the peritoneum in general, the condition becomes serious and septic shock may develop. Proper investigations and appropriate management should be confirmed.

Conflict of Interest
We declare that we have no conflict of interest.

References