LETTER TO THE EDITOR

# Difficult Retrieval of Glass Bottle in the Rectum: How the Story End?

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Dear Editor,

We read with great interest the article by Amran FA et al which was recently published in your valued journal (1). The authors had experienced a mentally challenged gentleman with a retained self inserted rectal foreign body (RFB) who came with usual abdominal symptoms. We congratulate the authors for giving us a detailed sequence of events in addition to a good quality of endoscopic and radiologic images.

We believe that the values of this article are slightly incomplete in certain aspects, which can be improved in the future. The authors had described typical clinical findings of colorectal malignancy and a low suspicion of RFB, hence the management flow skidded from the norm. We admit that in any abdominal symptoms, especially pain, blood-stained, mucus discharge and mass, the initial investigation after resuscitation should be an abdominal radiograph prior to a colonoscopy. It was proven significantly when a radiograph was undertaken to show a very obvious RFB. We disagree with the suggested pathway given by the authors in which initial imaging is paramount in an acute abdomen prior to any transanal or endoscopic procedure (2).

Besides, we think that the terminology used for the surgical technique is incorrect. The patient underwent retrieval of the RFB via laparotomy and sigmoid colon incision, hence double-barrel stoma was created. We believe that the proper definition is diversion loop colostomy instead of double-barrel stoma as no bowel resection was involved and it is the second most performed procedure after Hartmann's procedure or end stoma during trauma (3).

**REFERENCES**

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**Author response - Letter to the Editor: "Difficult Retrieval of Glass Bottle in the Rectum: How the Story End?"**

I agree on part of the flow chart need a bit of amendment by adding plain abdominal radiography examination if seem deems after the history and clinical assesment eventhough now a day most people skip plain abdominal radiograph examination of its limited information and proceed directly to computed tomography examination.

I did not explained in this paper that we proceeded with endoscopic examination as clinically the attending surgeon think it is more towards malignancy and endoscopy slot is available at that time. The attending surgeon proceed with endoscopy with intention to obtained tissue for histopathological examination. The attending surgeon also ordered for Computed Tomography scan but it was delayed as there was another patient doing it at the particular moment.

In regards of the loop colostomy, we do double barrel as we cut the colon into 2 part completely with no intention to reverse the stoma in the future.

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