SHORT REPORTS

Vaginal vibrator lodged in rectum

Vaginal vibrators and other sexual surrogates are readily available in most metropolitan areas in the USA, often over the counter in pharmacies. Although usually not advertised as such, they are designed for use within the vagina, which, being fairly short, makes their retrieval comparatively easy. But increasingly these devices are being used to gratify anal eroticism and may easily be inserted beyond the anal sphincters. These tend to close and to force a foreign object up the tract out of reach of the user, so that it has to be retrieved by surgery. We think these cases are increasing and that therefore the following reports are timely.

Case reports

A 40-year-old woman reported that the previous day, during sexual intercourse, her husband had inserted a battery-driven vibrator into her anus. In the excitement of the moment he had pushed the vibrator past the external sphincter and it was lost from his control. The patient was admitted to the hospital and under saddle-block anaesthesia the anus was dilated and the vibrator (fig 1) removed with forceps. Recovery was uneventful.

Another case was that of a 24-year-old woman who presented at the

Vaginal vibrator removed from rectum in case 1.

emergency room with a history that five days previously during intercourse her partner, at her request, had introduced into her rectum a vibrator similar to that in the first case, except that it was longer. The partner lost control of the vibrator, which disappeared beyond the anus. Attempts to retrieve it were unsuccessful. On examination the patient's anal mucosa was hyperaemic and superficially lacerated. She was suffering from abdominal pain, nausea, and anorexia and her abdomen was slightly distended. The vibrator could not be seen within 17 cm at sigmoidoscopy, and x-ray examination showed it lodged in the sigmoid colon. She reported that the motor had continued to operate for about five hours.

The patient was hospitalised and a nasogastric tube was passed to provide alternative proximal decompression. After decompression mineral oil as an emolient was introduced over a period of 24 hours. Then a mineral oil enema was given and a laparotomy was performed. No injury to the bowel was found. Since the x-ray examination the vibrator had moved up into the proximal descending colon, where it was held firmly by spasm of the bowel. It was carefully milked down the descending and sigmoid colon to the rectal ampulla. After this, with the patient placed in stirrups, the anal canal was dilated and, aided by manipulation from within the abdomen, the vibrator was withdrawn.

Discussion

The use of the foreign objects for anal stimulation is not new¹ nor is their removal by surgical means.² They have been mostly ordinary household utensils, bottles, sticks, or the like. Specially manufactured surrogate phalluses have been available since biblical times and before,³ but never before have such a variety of sophisticated devices been so readily obtainable so inexpensively. The permissiveness engendered by today's so-called "sexual revolution" has also done much to lessen the social stigma attending some of the more unusual modes of sexual gratification. We would therefore expect the use of these devices to increase and, concomitantly, the number needing to

be surgically removed from the rectum. We strongly recommend that doctors counselling patients should whenever possible emphasise the dangers of the rectal use of artificial phalluses designed for vaginal use. The law should require appropriate safeguards to be incorporated into the design to prevent their loss into the gastrointestinal tract, and they should be supplied with clear and unmistakable warnings about the dangers of improper use. Finally, the consequences of the misuse of vaginal devices might be a suitable subject for inclusion in appropriate programmes of sex education in schools and elsewhere.

¹ Haft, J S, and Benjamin, H B, *Medical Aspects of Human Sexuality*, 1973, 7, 74.

² Benjamin, H B, Klamecki, B, and Haft, J S, *American Journal of Proctology*, 1969, 20, 413.

³ Haft, J S, Benjamin, H B, and Zeit, W, *Medical Aspects of Human Sexuality*, 1974, 8, 54.

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Non-ketotic diabetic precoma associated with high-dose frusemide therapy

Diabetes mellitus is a complication of thiazide diuretic treatment¹ and glucose intolerance has been associated with frusemide therapy.² Thiazide diuretics may cause non-ketotic diabetic coma¹ but only four cases due to moderate doses (40–80 mg/day) of frusemide have been reported.^{3,4} We report a case of non-ketotic diabetic precoma in a patient receiving a high dose of frusemide for salt and water retention secondary to chronic respiratory failure.

Case report

A 61-year-old man presented in 1972 with a six-year history of progressive dyspnoea. He had gross salt and water retention secondary to chronic bronchitis. There was no glycosuria and a glucose tolerance test was normal. He was treated with digitalis, warfarin, frusemide (250 mg/day), a low salt diet (44 mEq (44 mEq) sodium), and continuous oxygen therapy. His condition improved and remained stable. From November 1974 his weight gradually increased by 8 kg, and his frusemide dosage was increased. He was taking 750 mg/day on 1 June 1975 when he was admitted to hospital confused and disorientated with blurring of vision, an extensive monilial rash in both groins, and a weight loss of 7.5 kg. There was heavy glycosuria with no ketonuria. The results of investigations were as follows: blood glucose 64 mmol/l (1150 mg/100 ml); plasma osmolality 360 mmol/kg (360 mosmol/kg); pH 7.39; plasma insulin 17.5 mU/l (normal range 4–25 mU/l); plasma sodium 120 mmol/l (120 mEq/l); plasma potassium 6.0 mmol/l (6.0 mEq/l); blood urea 23 mmol/l (140 mg/100 ml); haemoglobin 13.2 g/dl; packed cell volume 44.3%; and a total white blood cell count of $15.3 \times 10^9/l$ ($15\,300/mm^3$). Chest x-ray examination showed a decrease in transverse cardiac diameter (17.5 cm to 14.0 cm).

The non-ketotic diabetic precoma was treated with intravenous fluids, insulin, and potassium supplements. Nine litres of half-strength normal saline was given in the first 16 hours and 7 litres of normal saline with 52 mmol of potassium during the next 36 hours. Soluble insulin 36 U was given in the first 16 hours to reduce the blood sugar to 15.5 mmol/l (280 mg/100 ml), which was subsequently maintained at 6.7 mmol/l (120 mg/100 ml) with 112 U soluble insulin/day and a 135-g carbohydrate, 5.9-MJ (1400-kcal), 44-mmol sodium diet. One week after admission the patient developed increasing salt and water retention and treatment with frusemide was restarted. When discharged six weeks later he was taking frusemide 500 mg/