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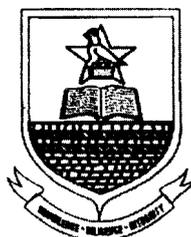
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Intra-abdominal gossypiboma: a report of two cases and a review of literature

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Abstract

Post operative foreign body in the abdominal cavity, though rare continues to occur in surgical practice. Symptoms may start early with abdominal pain but usually have a varying course, often leading to the formation of gossypiboma. This is usually a great source of embarrassment to the surgeon and the centre, and of serious detrimental effect to the patient.

A case report of a 27 year old trader with intra-abdominal foreign body is presented to highlight the similarity in presentation with abdominal lymphoma and the need to explore carefully masses in the abdominal cavity especially in patients who have had surgery in the past.

A high index of suspicion is required on the part of the clinician in addition to appropriate radiological and sonologic assessment. Prompt diagnosis and treatment ameliorates the patients suffering and brings them back to life.

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Introduction

Retained intra-abdominal foreign body is a rare complication of surgery. It is a world wide occurrence but its incidence is grossly under reported because of the embarrassment it causes to the surgeon and the centre, and the medico-legal implications. Such incidences acquire so much importance in modern times because of excessive media hype which can jeopardize the reputation of a surgeon amongst his professional colleagues and in the public at large.^{1,2} Various objects have been left behind in the abdominal cavity, particularly following emergency and/or bloody procedures. Materials left behind in the abdomen include gauze, sponges and haemostatic forceps. Abdominal sponges constitute 80% of such materials.^{3,4}

A case of a 27 year old woman is hereby presented to highlight the need for a high index of suspicion and prompt surgical intervention to return sufferers to normalcy.

Case Report 1: AB is a 27 year old woman who presented to the surgical out-patient clinic of the Irrua Specialist Teaching Hospital with complaints of abdominal pain of eight months duration, weight loss and constipation of six months. Past medical history showed that she had a Caesarian section in a private clinic 12 months earlier following obstructed labour. Post operative recovery was, however, said to have

been uneventful.

Examination revealed a chronically ill looking woman who was pale, but anicteric, and had no peripheral lymphadenopathies. Abdominal examination showed visible peristalsis, and a firm, irregular and tender mass measuring 10 x 8 inches, lying in the left lumbar region.

Packed cell volume was 27%, while ultrasound scan showed multiple abdominal masses with features suggestive of abdominal lymphoma. A clinical diagnosis of small bowel obstruction secondary to abdominal lymphoma was made, and the patient was worked up for exploratory laparoscopy. Operative finding included a mass surrounded by the omentum, loops of small bowel, and the descending colon. Attempt at separation revealed a cavity containing pus at the centre of which was a mop rolled into a ball. Around the main mass were multiple lymph nodes, which showed features of inflammation on histology. Fifteen cm of small intestine was resected and end to end anastomosis done. The patient was discharged home on the 10th post operative day and has done excellently well since then.

Case Report 2: UP is a 34 year old paraO¹ outpatient who had a Caesarian section (CS) for prolonged labour. The operation was said to have been uneventful. Two days after the CS the patient however, complained of severe and persistent lower abdominal pain that did not respond to analgesic. Ultrasound scan showed a

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complex mass in the right iliac fossa that necessitated exploratory laparotomy. Surgery was performed by the Gynaecology and Surgical team. An abdominal mop was found surrounded by loops of intestine and seropurulent exudates. The mop was removed with relative ease and the peritoneal cavity mopped dry. The patient had antibiotic cover post operatively and had an uneventful recovery thereafter.

Discussion

Patients often come down with a wide spectrum of complications in the post operative period after abdominal operations. These range from post operative ileus, vomiting, fever, recurrent abdominal pain, incisional hernia and adhesive bowel obstruction. It is usual, therefore, to presume that abdominal pain, as in the above patient, presenting several months after abdominal surgery is from bands or adhesions.^{2,3}

Gossypiboma is post operative foreign body granuloma in body cavities arising from cotton materials as in gauze, sponges or towels. It is derived from gossypium a Latin word for cotton, and boma a Swahili word for a place of concealment. Although it is rare, it may complicate abdominal, thoracic, spinal, orthopedic, neuro-surgical or even vascular surgeries.⁵

Surgical sponges remain the most commonly retained objects because of their frequent usage, small size and their amorphous nature.³ In the early period symptoms may be those of acute exudative inflammatory reaction which usually results in abscess, while the late feature is an aseptic fibrotic reaction leading to the formation of dense adhesions and mass, which may be clinically indistinguishable from post operative adhesive bowel obstruction and intra-abdominal neoplasm. This second mode of presentation leads to delayed presentations occurring after months or several years after the initial operation.^{5,7,8}

Diagnosis of gossypiboma is often difficult because, while some may be asymptomatic, others may present with life threatening conditions. The low index of suspicion due to the rarity of the condition and the long latency in the manifestation of the symptoms in many patients frequently results in delayed diagnosis and management⁴ many diagnostic features seen in CT scan, MRI and ultrasound scan have been highlighted in literature.

These features, though not very specific are enhanced by the presence of radio-opaque markers. In most developed countries, surgical sponges have radio opaque markers and can, therefore, be easily detected by standard plain abdominal radiographs.^{7,9} In our country, however, such radio opaque surgical sponges are not readily available, so information retrievable from plain radiograph is minimal.

CT scan is the best modality for identifying intra-abdominal sponges. Features include the appearance of circumscribed masses with thick wall. These masses might contain gas bubbles, may exhibit calcification, with their internal structures showing whirl-like or

spongiform appearance because of the presence of gas trapped within the mesh of the sponge.^{9,10} The non-availability and cost of getting CT scan in our low resource setting makes sonology, with its non-specific features, our imaging modality of choice in suspected cases of retained surgical sponges.

The treatment of this condition is surgical removal, with careful dissection of firmly adherent bowels. For patients presenting early, laparoscopic or percutaneous radiological removal may be attempted, but the patient must be carefully observed post operatively for features of small bowel injury. Post operative recovery is usually uneventful following surgical removal.^{2,7,11}

While highlighting the need for prompt diagnosis and treatment of retained sponges, there is the need to emphasize preventive measures. Risk factors commonly identified include emergency operations, unexpected change in operation, high body mass index, surgery by more than one surgical team, change in nursing staff during the same operation, volume of blood loss, female sex and failure of surgical count. The first three have, however, been established as significant.¹² Preventive measures, therefore, should include use of radiographically detectable sponges and towels, abdominal mops attached externally to clips, avoidance of small gauze in large cavities, surgical counts at the start of operation and before wound closure and routine wound examination before commencement of wound closure.^{5,12}

In conclusion, retained intra abdominal towels, though rare, occurs from time to time. Because clinical and radiological features are non-specific, a high index of suspicion will enhance early diagnosis in patients with post operative symptom. Adequate preventive measures should remain in the forefront of sound surgical practice.

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