Gossipyboma-A Case Report

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Introduction

Gossipyboma is a term used to indicate cotton based foreign body that is in a place of concealment following surgery. We herewith report a rare incidence of transluminal migration of a surgical sponge following previous surgery that had presented at our outpatient department with right iliac fossa pain and signs of subacute obstruction.

Forgetting a foreign body in the abdominal cavity is an unpleasant and avoidable situation. Surgeons may not report these events for fear of litigation and adverse publicity.

Case Report

A 32 yr old female presented at the outpatient department with pain in the right iliac fossa on and off for past 3–4 months. There was history of vomiting for 4–5 days prior to admission. Past history revealed undergoing LSCS 2 yrs ago.

On examination there was mild distension of abdomen and tenderness in the right iliac fossa. General condition of the patient was good. No mass was felt on palpation. There was no organomegaly.

Routine investigations were all within normal limits and ultrasonographic findings revealed probe tenderness in the right iliac fossa with mass lesion measuring 6x5x3 cm in the right iliac fossa. Exploratory laparotomy was planned. On exploration an 8x8x6 cm indurated mass of coiled intestine involving terminal ileum with surrounding dense adhesions was seen. Resection and end to end anastomosis performed. Cut section of the resected segment revealed a

laparotomy sponge within the intestinal lumen. Post operative period was uneventful. Patient recovered well and was discharged on the 6th day and sutures removed on the 11th day.

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Discussion

Gossypiboma is a term used to indicate cotton based (Latin - Gossypium) foreign body that is in place of concealment (Swahili) following surgery.

[1] Intraperitoneal forgotten foreign bodies are prone to create adhesions and to encapsulate, or to provoke an exudative response, with or without accompanying bacterial infection. Often a process of self-extrusion is initiated. This is also true for gossypibomas, retained surgical sponges. Presentation is possible as a pseudotumoral, occlusive, or septic syndrome; several cases, however, have remained asymptomatic for as long as several decades. Ultrasonography and radiology (especially computed tomography) contribute significantly to the detection of gossypibomas; magnetic resonance imaging is a less used technique. Detection by plain radiography is difficult. Ultrasonography demonstrates a hyperreflective mass with hypoechoic rim and a strong posterior shadow. Computed tomography shows a well defined mass with internal heterogenous densities. Therapy consists of operative removal of the foreign body in association with resolving its complications.

The inflammatory reaction elicited by the foreign body erodes and perforates the intestinal wall. Through the perforation, migration of foreign body takes place and further progressive migration takes place by the peristaltic activity until it gets trapped at the ileocaecal junction. If it passes through the ileocaecal junction, it either stays in the colon or is expelled per rectum. If it is in the colon, it can be manually milked out through rectum.

Retained sponges can often be asymptomatic, but can progress to abscess formation, fistula formation or obstruction. Radio opaque material are usually detected on follow up radiological investigations but radiolucent material such as sponges create diagnostic problems and clinically mimic various abdominal pathologies.

[2] Introduction of spiral CT, MRI and dedicated ultrasonography have enabled clinicians to find these foreign bodies. Spontaneous transluminal migration and expulsion per rectum of sponges without squeal is also possible. The best approach in the prevention of this condition can be achieved by following preventive protocols like meticulous count of surgical material and by routine use of surgical textile material impregnated with a radio opaque marker.

[3] The occurrence of a retained surgical sponge occurs with a frequency of one per 100–3,000 operations

[4] The most frequent site of migration is the intestine (75%), but migration into the stomach and into the bladder also in recorded. Only 6% cases describe a sponge spontaneously expelled through the rectum, whereas more than 93% need re-intervention

In the recent retrospective review, 69 % of retained foreign bodies involved sponges and 31 % involved surgical instruments. Most common locations were abdominal cavity (54%), vagina (22%) and thorax(7.4%). Retention is discovered at a median date of 21 days post-operatively but ranged up to 6.5 years.

[5] Risk factors for retention include: Emergency surgery (RR=8.8). Unsuspected change in procedure (RR=4.1) 3. Obesity.

Conclusion

To be able to diagnose a case of retained sponge in time, a high index of suspicion is required. Prevention can be achieved by thoroughly examining the operation field for any retained sponge, instrument or foreign material. Adoption of a very systematic swab and instrument counting policy is of paramount importance.

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