

INTRA LUMINAL GOSSYPIBOMA

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SUMMARY

Intraluminal gossypiboma is a serious but avoidable complication during surgery which can be averted. The whole surgical team has to be vigilant especially during the closure of surgery, the time when fatigue makes every one a bit careless which can be costly both for the surgeon and increases the morbidity and mortality of the patient. Simple precautions like gauze pieces counting and tagging the gauze pieces with markers can prevent this.

KEY WORDS: Gossypiboma.

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Gossypiboma is the technical term for a retained surgical sponge. It is derived from the Latin "gossypium" (cotton) and the Swahili "boma" (place of concealment). An instance of gossypiboma is not rare but migration intraluminally is relatively rare. Gossypiboma usually manifests as intestinal obstruction, sepsis, fistula and rarely intraluminal migration.

CASE REPORT

A 40 year old female who underwent cholecystectomy eighteen months back presented in emergency with acute small bowel obstruction.

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Past history revealed that she had episodes of vomiting previously. On examination she was dehydrated. Erect X-Ray abdomen showed dilated small bowel loops. Diagnosis of obstruction due to bands was made. After resuscitation she was operated and laparotomy was done. After entering the abdomen no adhesion was encountered. Small bowel was distended till mid jejunum. On palpation, a 10 cm. segment of jejunum was found to be solid, with a cord like structure undulating proximally, so the diagnosis changed to worm impaction. A proximal enterotomy was done to dis-impact the worm. On pulling out the cord like structure, a bile stained mop extruded from the jejunum. See Figure 1,2,3. Post operatively patient recovered unremarkably.

DISCUSSION

Gossypiboma has been reported to occur following surgical procedures such as abdominal, thoracic, cardiovascular, orthopedic, and even neurosurgical operations.¹ Although the real incidence is unknown, it has been reported as one in 100 to 3000 for all surgical interventions and one in 1000 to 1500 for intraabdominal operations.^{2,3}



Figure-1: Intraluminal mop

Retained gauze pieces have got a varied presentation. They may present in immediate post operative period as continued sepsis, or later on as fecal fistula. They are even cause of death. The retained gauze pieces inside the abdominal cavity incites inflammatory reactions and has varied presentations as those of abscess, mass etc.⁴ There are rare reports of their intraluminal migration and also spontaneous expulsion.⁵ This unfortunate problem arises due to negligence at time of operation due to improper counting of gauzes. It is the patient who bears the brunt of these mistakes, and becomes a surgical dilemma for treating surgeon. If the gauze pieces are not tagged with radio opaque markers the diagnosis is usually late and the patient in the meantime undergoes a battery of investigation for various other ailments.^{6,7}

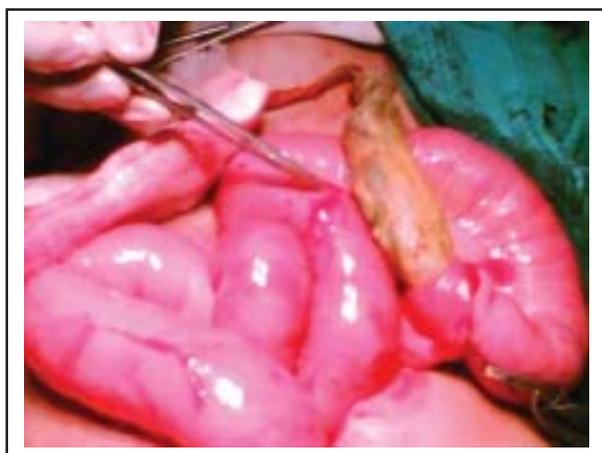


Figure-3: The whole mop after removal



Figure-2: Intraluminal mop

Apart from medical problems to patients, these can also have legal implication on surgeon. The presence of gauze pieces can easily be demonstrated by investigations. This may prove surgeon of criminal negligence.⁸ Moreover, gossypiboma may be misdiagnosed as a malignant tumor and lead to unnecessary invasive diagnostic procedures or extensive explorative surgery which may result in further complications.⁴

This problem can be easily avoided by proper counting of gauze pieces after operation. Avoidance of leaving foreign bodies inside the patients could be possible by implementation of three measures:

1. Meticulous count of all surgical materials.
2. Thorough exploration of the surgical site at the conclusion of the procedures, and
3. Routine use of surgical textile materials impregnated with a radio- opaque marker.

This emphasizes the importance of guidelines for operative theatre record keeping as recently issued by the Royal College of Surgeons of England.⁹ Gawande et al. has suggested the routine radiographic screening of high-risk patients before they leave the operating room even when counts are documented as correct. Although marked swabs and packs are widely used by vast majority of surgeons, there is no uniform policy towards this practice in some Eastern and Central/Southern European countries.²

Thus we can conclude that in all post operative cases presenting as emergency with obstruction should have Gossypiboma as a differential diagnosis and managed accordingly. Furthermore utmost importance to operative care for proper removal of all surgical instruments should be emphasized.

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