

Case Report

Thirty-three-year-old textiloma found during exploratory laparotomy: a case report

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ABSTRACT

The problem caused by a retained surgical sponge is known as a textiloma. Surgical gauze pads can be easily retained due to their ubiquitous use, their relatively small size, and when soaked in blood, making them difficult to distinguish from surrounding tissues. In most cases, the diagnosis of a textiloma is usually given in the following days of a surgical intervention, but there are few cases reported in the literature where a textiloma persists for a variable number of years. A 63-year-old female with a surgical history of a caesarean section 33 years ago complaining of an abdominal palpable mass and chronic abdominal pain. CT scan findings suggested the diagnosis of textiloma, the exploratory laparotomy revealed an encapsulated mass which was completely excised, and intraoperative study confirmed the diagnosis of textiloma. Textilomas occur infrequently and can be a source of great concern to the surgeon and the patient. Foreign bodies within body cavities and organs can present with several nonspecific clinical features that can make diagnosis difficult. An aseptic fibrotic reaction causes that the textilomas can remain asymptomatic for many years, with very few cases of 30 or more years old textilomas reported in the literature. Surgical removal remains as the treatment of choice. Textiloma can be a life-threatening problem that is an avoidable complication. Textilomas should be part of the differential diagnosis of abdominal tumors even after a 30-year surgical history.

Keywords: Gossypiboma, Surgery, Textiloma, Exploratory laparotomy, Differential diagnosis

INTRODUCTION

The work has been reported in line with the SCARE criteria.¹ The textiloma is defined as a mass-shaped lesion formed by a foreign body reaction formed around a gauze, sponge, forceps, or substances retained within the body of a patient undergoing surgery.² Generally, patients can present symptoms of inflammation and acute sepsis due to a foreign body reaction, but some cases have been described in the literature in which they can remain asymptomatic for a prolonged period. To our knowledge the maximum time of a reported textiloma case is 40 years.³ When high suspicion of textiloma is present X-ray images, ultrasound, computed tomography, or magnetic resonance are useful.⁴

The number of preoperatively diagnosed cases treated by exploratory laparotomy is rare in the literature. Most of the cases are diagnosed within the first days of a retained forgotten material.⁵ We report here a case who presented with an incidental finding during exploratory laparotomy with a history of caesarean section done 33 years ago in another hospital unit.

CASE REPORT

A sixty-three-year-old household female patient with a personal history of mellitus diabetes type 2, systemic arterial hypertension and four caesarean sections, last one performed 33 years ago. The patient was admitted due to the presence of an abdominal mass of one month history,

noticing it after a 25 kg weight loss under the supervision of a nutritionist for unspecified kidney disease, accompanied by a 6-month history of chronic abdominal pain. On physical examination, vital signs were within normal range, upon inspection a midline vertical scar was present with no visible mass. Abdominal exploration revealed a mass of 107× cm, mobile during lateral decubitus, located in left iliac fossa. Dull note was present on percussion. Rest of the physical examination was irrelevant. Her blood investigations were within normal limits and tumor markers tested negative. Contrast TC was performed (Figure 1) which showed a left hypoplastic kidney and a hyperdense oval image is appreciated in its center with well-defined borders, without evidence of infiltration to neighboring structures located in the left iliac fossa. The tomography was interpreted by the radiologist of our unit, who suggested the diagnosis of textiloma.

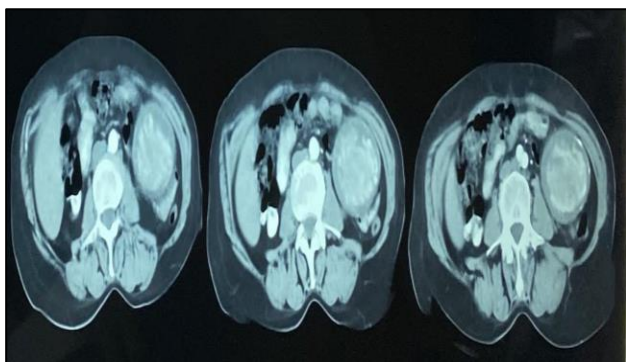


Figure 1: CT scan demonstrating a hyperdense oval image.



Figure 2: 10×7 cm encapsulated mass as textiloma.

Patient was prepared for surgery and was performed by head of the department of oncosurgery with 25 years of experience in the field of oncologic surgery and was assisted by one junior resident with 3 years of specialized training and one intern. The abdomen was opened and a pearly tumor of hard consistency with well-defined edges was evidenced, completely covered by the greater omentum, with loose and firm adhesions between the mesentery and the small intestine loops. A complete

surgical resection of the tumor was achieved (Figure 2), the rest of the cavity was inspected with no further findings and the abdomen was closed. The intraoperative histopathological report revealed a pseudocystic formation measuring 10×6.8×6.5 cm in maximum length with a surgical gauze-type textile content and fibrinous-purulent material inside (Figure 3). Patient recovered well postoperatively and was discharged 24 hours after surgery. A 6 month follow up showed no abdominal pain nor postsurgical complications.



Figure 3: Surgical gauze-type textile content and fibrinous-purulent material inside.

DISCUSSION

Based on reported epidemiological data, textilomas occur in 1 of 5500 to 18,760 inpatient operations, but the incidence may be slightly more common during emergency surgery.⁶ On the other hand, laparoscopic, endoscopic, and percutaneous procedures are less likely to lead to a retained sponge or instrument.⁷ The incidence of retained sponge depends on the anatomical location where the surgical procedure is performed; retained sponges in adults occurring more frequently in the abdomen (56%), the pelvis (18%), and the thorax (11%).⁸

Surgical objects forgotten and retained within some anatomical sites of a patient are very rare medical errors but have the potential to cause significant harm to the patient and carry both professional and legal consequences.⁹ However, there are cases where the forgotten object is encapsulated by the body and therefore remain asymptomatic for long periods of time, such as our patient with a 33-year-old case of textiloma.

The clinical manifestations of textilomas are intrinsically related to the body reaction, as well as the characteristics of the retained objects.¹⁰ The textiloma triggers two types of biological reactions, an aseptic fibrotic reaction or an exudative inflammatory reaction.¹¹ The first reaction usually forms an encapsulated mass. Patients generally remain asymptomatic or have nonspecific gastrointestinal symptoms such as dull abdominal pain or a palpable painless mass. On the other hand, the exudative

inflammatory response induces abscess formation. The disease can manifest as a serious clinical process that presents with acute abdominal pain and high fever. If not treated in time, it can induce intestinal or visceral perforation, or even intestinal obstruction, and formation of internal or external fistulas with adherent organs that can be due to the transmural migration of retained surgical gauze.¹²⁻¹⁵ The most unusual sequela is the erosion of the intestine by the gauze.¹⁶

In our clinical case, the retained surgical gauze lacked a radiopaque marker; therefore, the diagnosis was not possible with plain radiography. CT scans, interpreted by a radiologist, suggested the presence of a textiloma, regardless of the time of the last surgical act. The diagnosis of textiloma can be made by taking a careful clinical history, considering all risk factors (such as previous surgeries), physical exploration, and conducting some necessary imaging studies. Although some patients are diagnosed on the operating table during relaparotomy.¹⁷ In all cases, surgical exploration is the treatment of choice.¹⁸

CONCLUSION

Textiloma can be a life-threatening problem that is an avoidable complication of previous surgeries. Textiloma should always be considered as a differential diagnosis in a patient with abdominal pain and/or mass when an operative history is present. Surgical treatment remains the standard of choice, minimally invasive surgery is a promising alternative to laparotomy in the future. The textiloma should be part of the differential diagnosis of abdominal tumors, even with a surgical history of more than 30 years ago, as in our case.

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