



## CASE REPORT

### LAPAROSCOPIC REMOVAL OF FOREIGN BODY- A CASE REPORT

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#### ABSTRACT

Iatrogenic disease is defined as an illness caused by diagnostic procedures or treatment given by health care professionals. Iatrogenic foreign bodies are not uncommon in the medical literature. It is primarily as a result of human error and is reported rarely due to medico legal implications it carries. The varieties of foreign bodies like sponge, gauze, surgical instruments have been retrieved. Retained surgical sponge or gauze after operation is called Gossypiboma. It has varied and vague presentation and is also difficult to detect by radiological investigations.

#### INTRODUCTION

Post-operative retained foreign body has been estimated to occur once in 1000-1500 intra-abdominal surgeries. Urogynecological surgery is estimated to be the third most common cause of iatrogenic foreign bodies.<sup>1</sup> The risk is more in complicated cases like obese patients or emergent surgery, inadvertent trauma to tissues requiring more surgical instruments, retractors, surgical sponges, where the retained surgical sponges are the most common foreign body retrieved.<sup>2</sup> This surgical misadventure may occur despite preventive measures in operative room. Approximately 88% of retained surgical sponge occur in situation where the sponge and instruments counts were declared "correct".<sup>3</sup> It clinically manifests as acute reactions like inflammatory response, infection or abscess within days or weeks after the operation. It may also manifest as aseptic inflammation or exudative without infection leading to nonspecific manifestation.<sup>1,3</sup> In this case, retained surgical sponge was retrieved following 12 years of surgery.

#### CASE REPORT

A 37 years lady P4L3 visited our gynecological outpatient

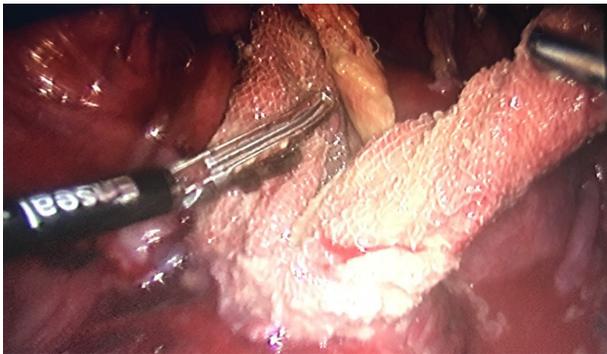
department with complaint of lower abdominal pain on and off for 1 year which was dull aching, radiating to bilateral flank, intermittent in nature, no aggravating factors and relieved on taking oral analgesics. It was not associated with nausea, vomiting and bloating. She had no history of shortness of breath and orthopnea. There was no associated bladder or bowel symptoms or feature of liver dysfunction. There was no history of fever, weight loss and loss of appetite.

She had her menarche at the age of 15 years, with menstrual flow of 5 to 7 days with regular cycle of 28 to 30 days with dysmenorrhea. She was P4L3, with her first 3 pregnancies delivered at home, in the presence of traditional birth attendant. Her antepartum, intrapartum and postpartum periods were uneventful except she had stillbirth in second pregnancy. She underwent Lower Segment Cesarean Section (LSCS) for transverse lie 19 years back for her last childbirth. Following LSCS, she started having incontinence of urine on seventh post-operative day and was diagnosed as obstetric fistula. She had Vesico-Vaginal Fistula (VVF) repair in India 19 years back. However, as symptom was not relieved, she had second attempt of VVF repair 2 years following. She was not relieved of symptoms, so she had third attempt of VVF repair by abdominal approach three years following second surgery.

Her intraoperative and postoperative periods were uneventful. However, she got relieved of symptoms. Since one year, she was having a vague abdominal pain for which she visited our hospital.

On examination, her general condition was fair and vital signs were within normal limits. There was no jaundice, edema, and lymphadenopathy. Precordial examination showed normal first and second heart sounds, no murmur was heard. On abdominal examination showed soft, non-tender, no mass was palpable, and there was no hepatosplenomegaly. On local examination of genitalia and breast showed age appropriate development of secondary sexual characteristics. In per vaginal examination uterus was of normal size and mobile. A mass of around 8x8cm was palpable in left adnexa which was tender, non-mobile, non-movable with movement of cervix, cervical motion tenderness was negative.

Trans abdominal sonography showed a mass of 7x7.8 cm with loculated cyst with multiple thin septations likely of adnexal origin. The uterus was normal with normal endometrial thickness.



**Figure 1:laparoscopic removal of retained surgical sponge (Gossypibium)**

Laparoscopy was performed on 29<sup>th</sup> of May, 2019 where a tetra of length 6x6cm was retrieved (Figure 1). There was thick pus collection organized around tetra in Right adnexa. Adhesion was present between omentum and anterior wall of uterus. Bilateral tubes were ligated and ovaries were normal. Pus was drained and washing was done. She was discharged on third postoperative day, and her hospital stay was uneventful.

## DISCUSSION

The natural history of objects left in the body during surgery

is highly variable. Objects can be recognized incidentally during the postoperative period, manifest themselves clinically through symptoms or complications or lay dormant for years. Clinical morbidity resulting from retained surgical sponges includes pain, persistent inflammation, obstruction, or septic complications.

It is difficult to diagnose retained items in asymptomatic patients. These items can sometimes be noticed incidentally in radiological imaging like X-ray, magnetic resonance images, computed tomography, and ultrasonography.<sup>4</sup> Radio-opaque markers found in foreign bodies help us to identify the mass. In USG, it is seen as a uniformly bounded mass, hyperechoic in the middle and hypoechoic in the sides, with intense acoustic shadow in the background. In CT scan, a spongiform mass composed of air-filled holes among fibers of gauze and the contrast-holding fibrotic capsular appearance is typical. Final diagnosis is reached in surgical exploration.

Reoperation is required for removal of retained foreign body. There are reports of diagnosis and removal by laparotomy and even by laparoscopy. As seen from the patients presented, the overall burden on the patient with retained surgical sponge following laparotomy is heavy, ranging from prolonged morbidity and hospital stay, multiple surgical interventions, costly investigations, increased overall cost of care, psychosocial distress to mortality.<sup>4</sup>

In our case, the diagnosis has been made incidentally following laparoscopy. The presenting symptoms and the previous gynecological operation should have been considered for the suspicion for gossypiboma.

## CONCLUSION

A high index of suspicion is required to make early diagnosis of retained surgical sponge following laparotomy and should be considered in any patients presenting with symptoms at any time following abdominal surgery. Hospitals and health policy makers should ensure that all theatres carry out comprehensive preventive measures routinely. Operating surgeons should actively supervise these measures and should always remember to explore the surgical wound and not depend solely on the 'accuracy' of the swab and instrument count to prevent retention of surgical sponges. Such case can be managed effectively by laparoscopic approach which is associated with minimal complications.

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