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Case Report

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AN ALIEN IN THE ILEUM :A RARE CASE OF INTRALUMINAL GOSSYPIBOMA

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ABSTRACT

Gossypiboma is a mass of cotton matrix that is left behind in a body cavity during a surgery. Gossypiboma is an infrequent cause of patient and physician discomfort, inviting major medico legal complications .a 39 year old female presented to us with complaints of abdominal pain of 1 month duration with no features of intestinal obstruction. An intraluminal gossypiboma was confirmed in the distal ileum on CT evaluation .Intraluminal migration and absence of intestinal obstruction sets our case apart from the usual clinical setting of gossypiboma.

KEYWORDS: Gossypiboma, Intraluminal.

INTRODUCTION

Gossypiboma is a mass of cotton matrix that is left behind in a body cavity during a surgery .The most common cause of gossypiboma is retained surgical sponges .Most gossypbiomas are described in abdominal cavities; however other sites like neck ,thorax etc are also reported[2] .Use of radio opaque markers in the surgical sponges have reduced the diagnostic dilemma associated with gossypbiomas ;however radio opaque markers may be distorted by folding ,twisting or disintegration over a period of time on radiographic evaluation[1] .Infrequent use of radio opaque markers may add to the problem of under diagnosis and under reporting. The actual incidence of gossypiboma is unknown ,however it is mentioned to be 1 in 100 -15000 of all abdominal surgical operations .Gossypbiomas account for 50 % of all medico legal problems for retained foreign bodies.

CASE REPORT

39 year old female presented to us with complaints of abdominal pain in the umbilical region since 1 month. She also had complaints of significant weight loss and nausea of same duration. She had no complaints of constipation or fever. She had complaints of vague abdominal pain for the past two years for which she was on regular antacids. She had undergone 2 caesarean sections; the last one was 12 years back. On examination, a vague abdominal lump was palpated in the umbilical region, with ill-defined borders. Lab investigations were within normal limits.

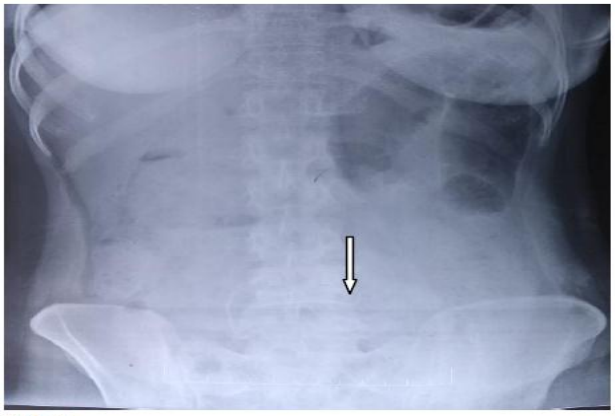


Fig. 1. Abdominal x-ray revealed an added radio-opacity in the lower abdomen (figure: 1).

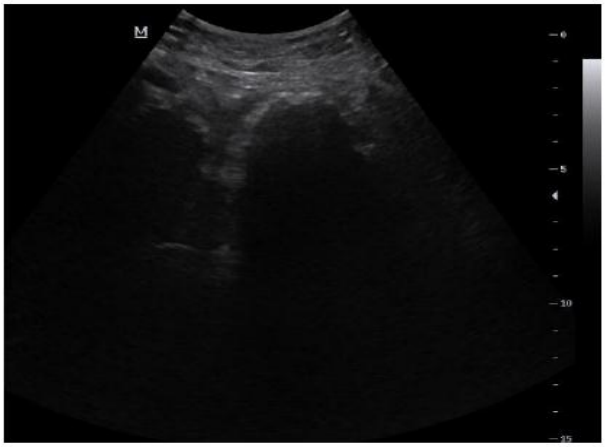


Figure. 2. Ultrasound evaluation revealed a hyperreflective curvilinear area with dense posterior

acoustic shadowing in the umbilical region and hypogastrium.

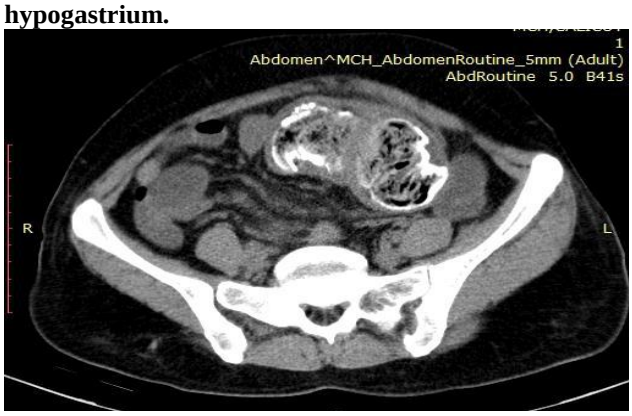
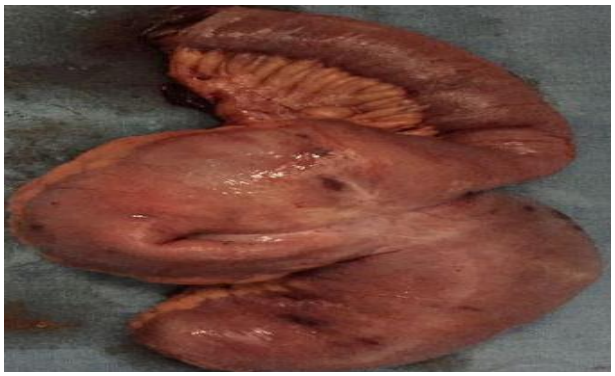
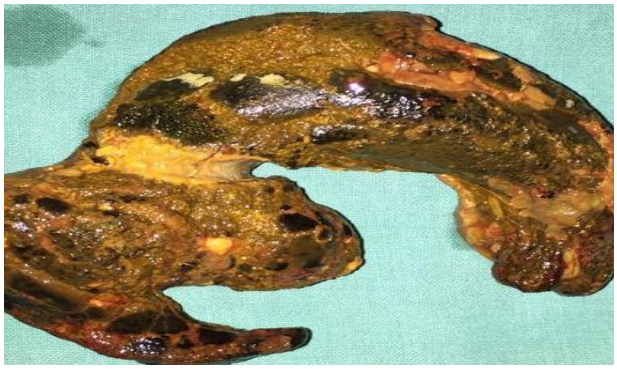


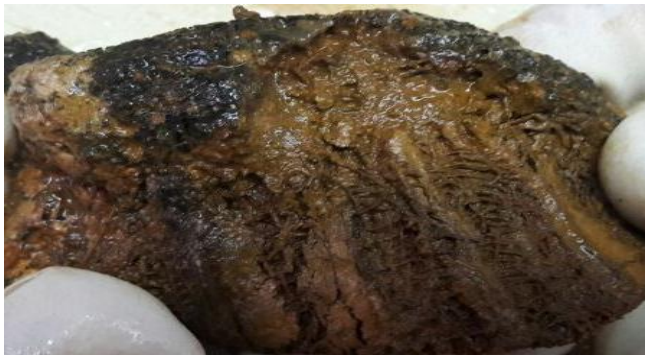
Figure. 3. CT evaluation revealed a heterogeneous soft tissue density mass noted within the distal small bowel loop with peripheral calcification and central mottled air foci within.



Post operative specimen shows a massively dilated loop of ileum with areas of adhesions.



Cut section of the dilated bowel loop shows an intraluminal hardened faecal matter.



Cut section of the hardened faecal matter shows a gauze stained with fecal matter within.

A diagnosis of intraluminal gossypiboma was made. The patient underwent explorative laparotomy. Intra operative finding was an intraluminal mass in the ileum about 90cm from ileocaecal junction. Segmental resection of the affected loop with ileo-ileal anastomosis was done. A provisional diagnosis of phytobezoar was made and the specimen was sent for histopathological examination. Histopathology confirmed the diagnosis of gossypiboma.

DISCUSSION

Abdominal gossypibomas are usually found in the peritoneal cavity. Clinical presentations of gossypiboma are varied; the usual one being an exudative inflammatory reaction with abscess formation and early detection. Another clinical scenario is aseptic fibrotic reaction with mass formation[2]. The pressure effect exerted by the mass thus formed can lead to necrosis and erosion of the adjacent bowel loops. The sponge might then enter the adjacent bowel loops and can cause obstruction or fistulation[3]. Patient can develop symptoms of intestinal obstruction or a malabsorption type syndrome caused by multiple internal fistulas or intraluminal bacterial overgrowth[4]. Here we report a case of intraluminal gossypiboma presenting as abdominal pain and weight loss. Intraluminal gossypbiomas are rare in incidence. In our case, patient has presented 12 years after the surgical procedure. She was completely asymptomatic for first 10 years. Another intriguing factor in this case is the absence of any prominent features of intestinal obstruction. Chronic ingestion of antacids in this case might have contributed to the peripheral calcification. Chronic antacid ingestions have been reported to cause bezoar formation.

CONCLUSION

The possibility of gossypiboma as an abdominal lump is a rarely made diagnosis. Our case explains the need for inclusion of gossypiboma as a differential in postoperative cases. CT evaluation is considered as the best modality for detection of gossypiboma.

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