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# Abdominal textiloma: about 2 different anatomo-clinical entities

**Abdou NIASSE*[1], Papa Mamadou FAYE [2], Abdourahmane NDONG [3], Ngoné Diaba DIACK [4], Mohamadou Lamine GUEYE [5], Ousmane THIAM [6], Ahmed DIOUF [7], Abdoulaye LEYE [8], Mamadou CISSE [9], Madieng DIENG [10]**

*1 General surgeon, surgical department, Pikine hospital (Dakar-Senegal)*
*2 General surgeon, general surgical department of Aristide Le Dantec hospital (Dakar-Senegal)*
*3 General surgeon, general surgical department of Aristide Le Dantec hospital (Dakar-Senegal)*
*4 General surgeon, general surgical department of Saint-Louis hospital (Saint Louis-Senegal)*
*5 internist, internal medicine department, Pikine hospital (Dakar-Senegal)*
*6 General surgeon, general surgical department of Dalal Jamm hospital (Dakar-Senegal)*
*7 General surgeon, general surgical department of Aristide Le Dantec hospital (Dakar-Senegal)*
*8 internist, internal medicine department , Pikine hospital (Dakar-Senegal)*
*9 General surgeon, general surgical department of Dalal Jamm hospital (Dakar-Senegal)*
*10 General surgeon, general surgical department of Aristide Le Dantec hospital (Dakar-Senegal)*

*Corresponding Author: Abdou NIASSE, *General surgeon, surgical department, Pikine hospital (Dakar-Senegal)*.
email: niasseabdou30@gmail.com

## Abstract

The lack of concentration during surgical intervention can lead to operative incidents and an oversight of foreign body in the abdominal cavity. Several factors are implicated in the occurrence of this complication such as emergency procedures, intraoperative bleeding, obesity and the unexpected change in surgical procedure. The oversight of compresses in the peritoneal cavity manifests with different manners including serious anatomo-clinical presentations. We report two cases of intra-abdominal textilomas in patients aged 23 and 60 years, respectively. They reported respectively a past medical history of cesarean section and laparotomy. The physical examination found a peritoneal irritation and an infectious syndrom. The ultrasound found multiple and diffuse intraperitoneal collections. Surgical exploration by laparotomy revealed respectively purulent peritonitis with a textiloma on the left flank and generalized purulent peritonitis with an intraluminal intestinal migration of textiloma. We performed respectively an extraction of the textiloma with peritoneal toilet, drainage and a textiloma extraction with intestinal resection and an end-to-end anastomosis with drainage. The post operative outcomes were unremarkable.

**Conclusion**

The anatomo-clinical presentation of the textilomas is very polymorphic. The vital consequences and the medico-legal implications mean that these incidents must be prevented by counting procedures, checking of surgical sponge and intraoperative vigilance.

**Keywords:** surgical sponge, foreign body, textiloma.

## INTRODUCTION

The textiloma corresponds to the forgetting of a textile foreign body during surgery. Textile fibers cause an inflammatory reaction with exudation from the 24th hour, followed by the formation of granulation tissue (day 8), and finally fibrosis from day 13 [1]. The possibility of infection and encystment in the

evolution or even calcifications with a tolerance sometimes long, explains the various anatotomo-clinical tables acute, sub-acute and chronic [2]. History of surgery, radiological exams including ultrasound and computed tomography can help diagnose textiloma. Surgical exploration allows the extraction of the foreign body and completes the lesion assessment [3]. We report the observations of two patients who presented with textilomas with different clinical pictures. Our objective was to describe the particular aspects of the two anatomo-clinical pictures.

**1st Patient**

It was a 60-year-old patient, Vèime gesture Vèime pare. She had a history of laparotomy 4 months before her admission for an acute intestinal obstruction on a spontaneous bridle without necrosis. The operation, which consisted of a bridle section, was performed by a senior surgeon between 2 a.m. and 3 a.m. The patient presented with intense diffuse abdominal pain evolving for several weeks associated with vomiting without stopping the transit.

The temperature was 38.8 ° C, blood pressure 110mmhg / 80mmhg. The physical examination found a scar of the xypho-pubic mid-laparotomy, a slightly distended sensitive abdomen with cry of the navel and generalized defense. The rest of the exam was normal. Biology found leukocytes at 19660 / mm3, a hemoglobin level of 9.4g / dl. The renal checkup, blood ionogram, liver checkup and EKG were normal. The abdominal ultrasound showed diffuse echogenic and heterogeneous peritoneal effusion with significant intestinal distention. After a short resuscitation using vascular filling, antibiotic therapy and analgesic treatment, an exploratory laparotomy was performed. It made it possible to find a mixture of diffuse serous and purulent liquid, numerous hale-parietal and hale-hail adhesions, a hail distension upstream of an ileal perforation at 210 cm from the ileo-caecal angle. The perforated loop was the seat of a tissue mass that corresponded to a phagocytic abdominal compress (Figures 1 and 2).

The gestures carried out were aspiration with sampling, intestinal resection followed by an end-to-end anastomosis then by a peritoneal toilet and drainage. The suites were simple. Transit resumed on the 4th post-operative day and the drain removed on the 5th day. Bacteriology had isolated Escherichia Coli sensitive to aminopenicillins. The consequences were simple after 7 months of follow-up.

**2nd Patient**

It was a 23-year-old patient, a primigravid primiparous woman. She was received at one month of a low transverse cesarean section for diffuse abdominal pain associated with vomiting in a febrile context without genitourinary signs. The indication for cesarean was pre-ruptured uterus and the procedure was performed by gynecologists in training between 3 a.m. and 5 a.m. The temperature was 36.8 ° C, the blood pressure 100mmhg / 70mmhg. Physical examination found a transverse scar suprapubic, a painful abdominal defense generalized with cry of the navel without palpable mass. Pelvic feel found a cry from the Douglas. The rest of the exam was normal. Biology found leukocytes at 4710 / mm3, a hemoglobin level at 11.1g / dl. The kidney workup and blood ionogram were normal. The abdominal ultrasound showed numerous stovepipe collections between the handles and intestinal distension. After a short resuscitation with vascular filling, antibiotic therapy and analgesic treatment, a middle and upper umbilical laparotomy was performed. It made it possible to find an adherent magma between the intestine and the abdominal wall at the level of the left flank, the adhesiolysis of which allowed 1000 ml of free pus to weld in a shell. In this cavity, was housed an abdominal compress strongly adhering to the posterior parietal peritoneum (Figure 3)

Elsewhere, there were numerous pockets of pus between the handles and utero-parietal and grêlo-utero-parietal adhesions. The annexes were without particularities. The gestures carried out were aspiration with sampling, adhesiolysis and extraction of a compress, followed by a peritoneal toilet and drainage. The suites were simple. Transit was resumed on the 2nd post-operative day and the drain was removed on the 5th day. Bacteriology had isolated Escherichia Coli sensitive to fluoro-quinolones. The consequences were simple after 8 months of follow-up.

## RESULT AND DISCUSSION

Textiloma is a rare postoperative complication [4]. Its discovery is generally late because the clinical picture is polymorphic [1, 5]. In our patients, peritoneal irritation syndrome was at the front of the table with no palpable mass. Some authors report the palpation of the textiloma in the form of a non-specific sensitive ovoid mass [1, 3, 6, 7]. The clinico-biological inflammatory syndrome observed in one of our patients can be explained by the reactions of the foreign body with the neighboring structures. As reported in the literature, long-term encystment and phagocytosis of the foreign body mean that the discovery may occur several months or even several years after surgery [1, 2]. In one of our patients, the intra-digestive migration of the abdominal compress made the clinical picture non-specific and the discovery at 4 months after a laparotomy. Imaging plays an important role in diagnosis. Ultrasound can show the foreign body with extra-digestive air bubbles [1, 8]. Being a dependent operator, the existence of digestive distension can make exploration difficult as noted in our patients. According to some authors, computed tomography is the most sensitive examination. Computed tomography allows precise preoperative topographic diagnosis. At the same time, she performs a complete exploration of the abdominal cavity in search of complications (fistulas, pneumoperitoneum, abscess). Some teams offer MRI explorations [9]. Indeed, the textiloma can mimic a connective tumor. The forgetting of foreign bodies (compresses, needle, instruments) in the peritoneal cavity is a

serious medical fault, several favorable factors of which have been identified [10, 11, 12]. Massive intraoperative hemorrhage with excessive use of compresses, fatigue, unexpected change of procedure and a faulty checklist are all factors implicated in the occurrence of textilomas [12, 13]. In our patients, the decrease in alertness can be accused of the occurrence of this incident given the late time of the intervention. Elsewhere, the lack of experience of junior surgeons may also explain the forgetfulness of the compress in our second patient.

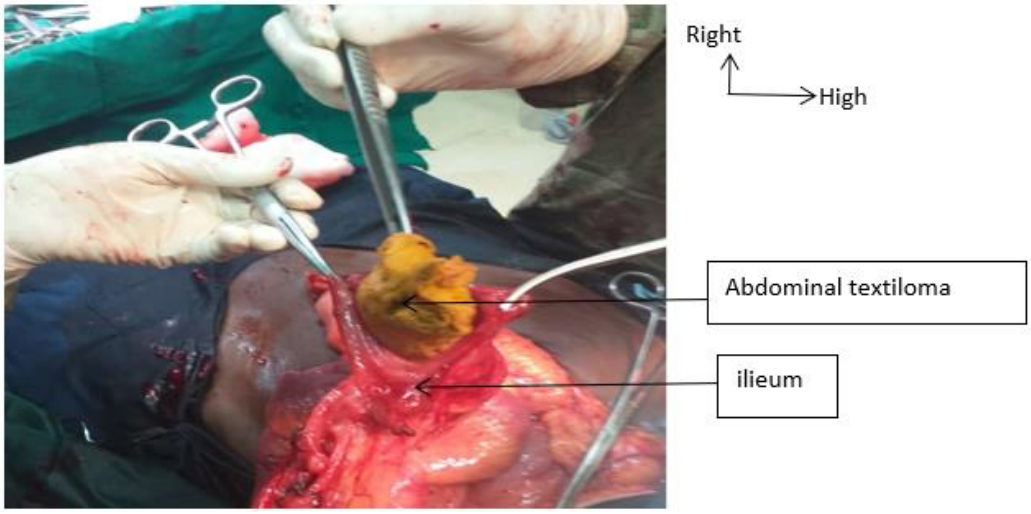


**Fig. 1:** Extraction of textiloma of ileum in 1st Patient

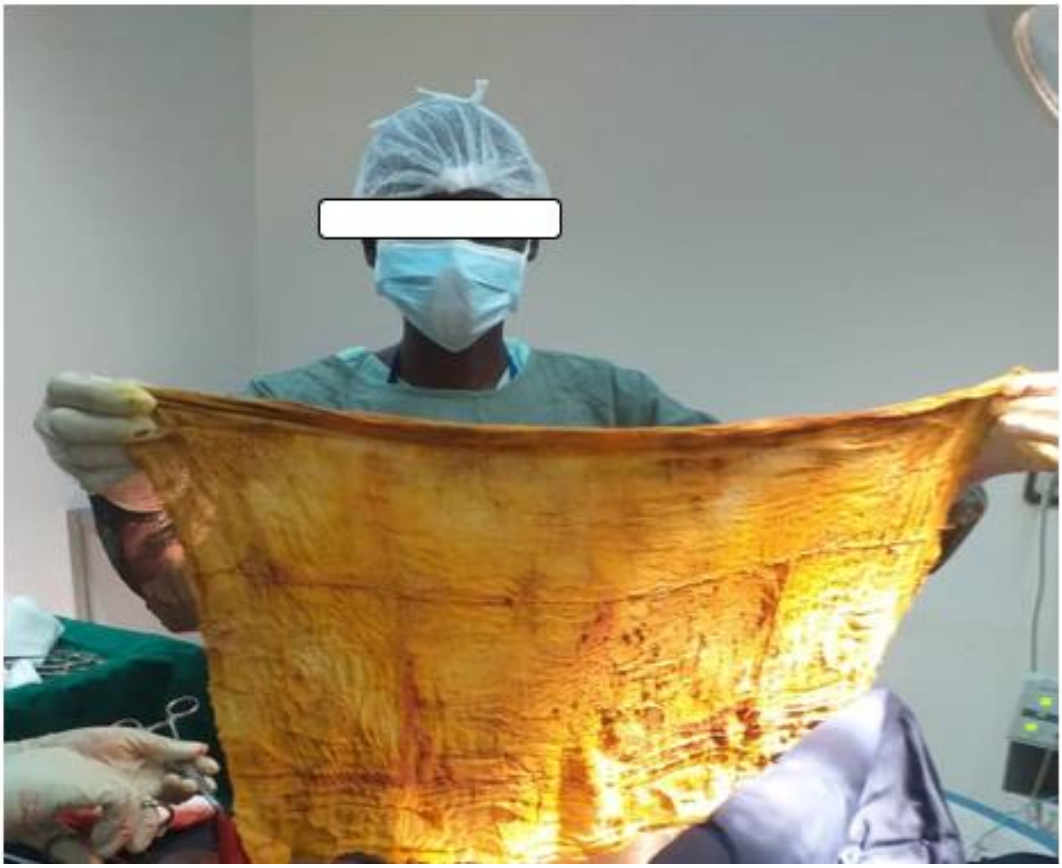

**Fig. 2:** Spreading textiloma in 1st Patient

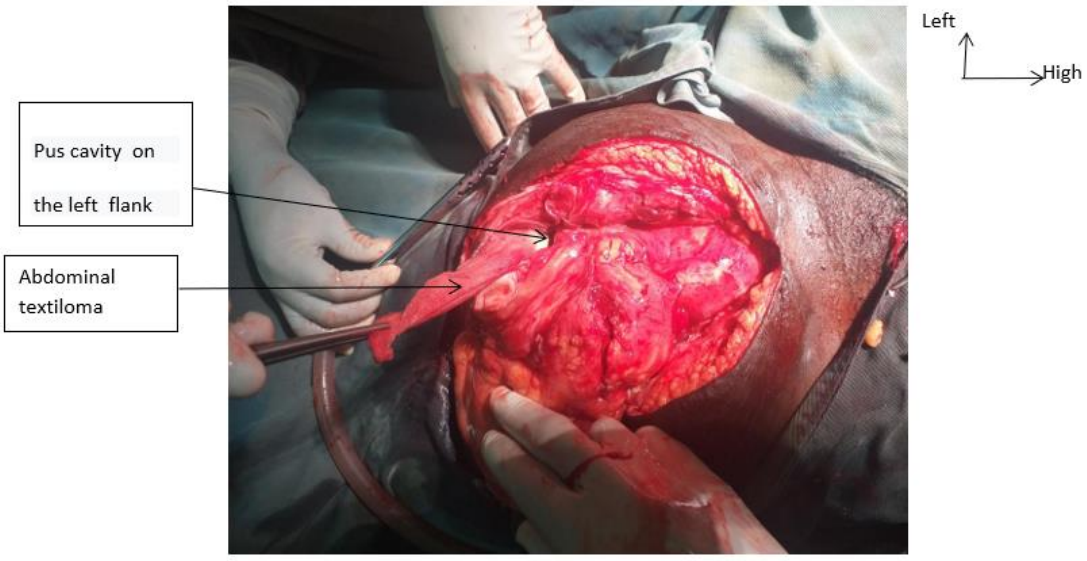


**Fig. 3:** Extraction of intraperitoneal textiloma in 2nd Patient

## CONCLUSION

Forgotten textile foreign bodies in the peritoneal cavity are rare. This is a very serious incident with a polymorphic clinical picture. The anatomo-clinical consequences mean that these incidents must be prevented by counting procedures, marking of compresses and intraoperative vigilance.

**Conflicts of interest**

The authors declare that they have no conflict of interest.

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