
CASE REPORT

Spontaneous Per Urethral Expulsion of Gossipibyoma – A Rarity

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ABSTRACT

Foreign bodies left accidentally during a surgical procedure are rare. In spite of careful intra-operative precautions and gauze counts mistake still occurs. Many of these cases present with sepsis, the foreign body may erode hollow viscera with and without signs of peritonitis and discovered on laparotomy. These foreign bodies may remain silent for years. We are reporting an interesting case of an 11 years old girl who presents with gauze piece coming out of her urethra 4 years after cystolithotomy and right ureterolithotomy. Such cases of intraluminal migration and spontaneous expulsion of foreign body are rarely reported.

Key words: Foreign bodies, Gossipibyoma, Retained foreign bodies, Retained surgical sponge.

INTRODUCTION

Foreign bodies left accidentally during a surgical procedure are rare. These foreign bodies are of varied types and range from instrument to gauze piece. Among them surgical sponge is the most common. They account for less than 0.01 % of abdominal surgeries¹. Such incidents are more commonly seen in general surgical, gynecological, obstetrical and urological surgeries but can occur in any surgical specialty².

These foreign bodies usually induce foreign body reaction and present early, but they may remain silent for years and present as pseudotumor called gossipibioma. Many times these foreign bodies erode nearby hollow viscera and present with signs & symptoms of peritonitis or sepsis and the foreign body are discovered on exploration³. These left over foreign bodies often have severe medicolegal issues.

Herein we are reporting rare case of a girl who had cystolithotomy & right ureterolithotomy, she presented 4 years later with ribbon gauze protruding from her urethra.

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CASE REPORT

An 11 year old girl presents in a private hospital with the complaints of something coming out of vulva for 2 hours. She also had severe dysuria, increased frequency of micturition and urinary incontinence for the last 4 days. She had past history of cystolithotomy and right ureterolithotomy 4 years back in the same hospital by someone else. She had an attack of urinary tract infection 2 months back that settled down on oral medications.

For the last 4 days she had severe dysuria, increased frequency of micturition and episodes of urinary incontinence. For this she went to a urologist who further investigated her. At that time her urinalysis showed numerous pus cells and red cells. X-Ray KUB revealed a radiopaque calculus in the bladder (Photograph - I). Ultrasound KUB showed thick walled urinary bladder with multiple calculi. On the bases of these she was diagnosed as a case of recurrent vesicle calculus. She was catheterized and sent home with the plan of cystolithotomy after 5 days as the consultant was going outstation.

In the morning she took out her catheter with the help of a nurse on her own, as she was irritated with it. After few hours she noticed something coming out of her vulva. She tried to pull it out but it was painful, so she was brought to the hospital by her parents.

On examination a piece of gauze 3 to 4 cm long was protruding from the urethra. As the child was irritable it was planned to remove under general anesthesia. On examination under anesthesia the gauze piece was found coming from the external urethral meatus, the hymen was intact (Photograph - II). When it was pulled out a piece of ribbon gauze about 10 cm long came out and on its distal end a calculus 2 x 1 cm in size was attached that also came out along with it (Photograph - III).



Photograph 1: X-Ray Pelvis Showing Radiopaque Calculus in the Urinary Bladder



Photograph 2: Ribbon Gauze Coming from the External Urethral Meatus, and Intact Hymen



Photograph 3: Ribbon Gauze Piece Removed From The Urinary Bladder Along With Calculus Attached At Its Tip

Post operative X-Ray KUB was normal, however her ultrasound KUB still showed some foreign body in the urinary bladder. Her cystoscopy was then performed and a second piece of ribbon gauze about 4 cm long was again removed. The anterior wall of the bladder showed a small hyperemic area. Later her C.T. scan of pelvis was performed and was found to be normal.

DISCUSSION

Foreign bodies left during surgery have serious implications. Although it is rare, it may vary from sponge to instrument. Surgical sponge is the most common foreign body left over during surgery. It has been reported to occur following abdominal, thoracic, gynecological, orthopedic, and even neurosurgical operations, but can occur in any field of surgery². It is more common in abdominal and gynecological surgeries where deep cavities are explored especially in obese patients and when the surgery was performed in emergency situations⁴.

Surgical sponge or gauze piece left during surgery can be potentially life threatening and has serious medico legal implications. Although it is rare, the exact incidence is not known. It is estimated to account for less than 0.01 % of intra abdominal surgeries¹.

These retained gauze piece induces a foreign body reaction in the in the surrounding tissues and depending upon whether they are sterile or infected presents early or late. They produce diagnostic difficulties as their presentation is quite varied³. They may present early in immediate postoperative period as continuing sepsis or they may remain silent for years. Later granuloma may form around them and presents as abdominal mass mimicking a tumor (Pseudotumor) this tumor like mass is called Gossipyoma. Clinically it is very difficult to accurately diagnose them⁵.

Sometimes these left over foreign bodies erodes a neighboring hollow viscus and presents as sepsis or fistula formation even after years of operation such sepsis may be life threatening^{6,7}. In addition intraluminal migration and spontaneous expulsion of such foreign bodies are rarely reported.

In our case after cystolithotomy and right ureterolithotomy the patient remain asymptomatic for 4 years. Her symptoms started 2 months back as increased urinary frequency and dysuria which was diagnosed and treated as urinary tract infection. Later she develops the same symptoms that progress to urinary incontinence. At that time she was seen by a urologist who investigated her and the reports at that time revealed stone in the bladder. The X- Ray picked the secondary stone formed on the foreign body; it was unable to pick the gauze piece as it was not labeled with radio opaque marker. Similarly the sonologist was unable to pick up the foreign body initially probably because it was overshadowed by the echoes produced by the secondary calculus. Later after removal of the prolapsed gauze piece along with the stone the sonologist was able to detect residual gauze which was removed cystoscopically. The hyperemic area in the anterior wall of bladder is probably the site from where the sponge has entered.

Although extrusion of retained surgical sponge in to a hollow viscus (Transmural migration) is known^{6,7} but intraluminal migration is a rare phenomenon. Cases were reported where laparotomy sponge extrude into the bowel lumen without clinical signs^{8,9} and migrate distally causing intestinal obstruction^{8,9,10}. Similarly migration of surgical sponge into the urinary bladder after herniorrhaphy had also been described^{11,12} but spontaneous extrusion through the bladder is rare and as far as our knowledge is concerned and after thorough literature search no such case has been found.

The retained foreign bodies represents serious ethical and legal dilemma. Although it is serious, but can be avoided. The whole surgical team has to be vigilant especially during closure. This problem can be prevented by: 1- Careful handling of gauzes during surgical procedures. 2- Thorough double counting of the gauzes before closure of wound and at the end of operation. 3- Thorough exploration of the surgical site at the end of procedures 4- Routine use of sponges and gauzes impregnated with radio opaque marker. 5- Routine radiographic screening of high risk patients before they leave the operating room, even when the gauze counts are documented as correct¹³.

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