

Textiloma: A Case Report of Rectal Expulsion

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Abstract

Textiloma is a rare pathological entity which can possibly complicate any surgery. Its incidence, reported in literature, is estimated between 1/1000 and 1/15,000. Abdominal and gynecological surgeries are responsible for the vast of majority of intra abdominal textiloma. Very few cases of spontaneous rectal expulsion of textiloma have been reported. We report the case of rectal expulsion of textiloma in a 26-year-old female who had undergone a C section for dynamic dystocia a year prior to her admission.

Keywords

Textilome, Rectal Expulsion, Colonoscopy

1. Introduction

Textiloma or retained surgical foreign body is a rare, medically related error, potentially life threatening, which can complicate considerably any type of surgery. Unfortunately, it often leads to additional and repeated surgery hence associated with higher rates of morbidity and mortality. On the other hand, there are very few cases relating to spontaneous rectal expulsion of textiloma or other retained surgical foreign bodies [1]. Thus we hereby report a case of textiloma expelled in faeces in a 26-year-old female with previous medical history of C-section for dynamic dystocia a year prior to her admission.

2. Case Report

Patient, 26-year-old mother who underwent a C-section a year prior to her admission for dynamic dystocia with uneventful immediate postoperative recovery. Six months later, patient presented with generalized abdominal pain and a painful swelling in the right lower quadrant. Clinical examination found a visibly sick afebrile patient, stable vital signs, with abdominal palpation revealing a ten-

der mobile mass in the right iliac fossa measuring about 10 cm. Abdominal scan showed a tumor-like lesion of the caecum (**Figure 1(a)**), without signs of lymphatic invasion nor metastatic disease. Colonoscopy was performed revealing a foreign body at the last ileal loop (**Figure 1(b)**) with failed endoscopic extraction. Hence, patient was scheduled for elective surgery. However, the clinical course was marked a few days after endoscopy by a spontaneous rectal expulsion of a green surgical towel (**Figure 1(c)**). The patient was closely monitored for 48 hours with physical examination showing no signs of peritoneal irritation and laboratory tests unremarkable. During a six month follow up, regular visits also remained unremarkable.

3. Discussion

The term “textiloma” commonly refers to a retained surgical foreign body (usually a textile material in the form of gauze or sponge) unintentionally left behind after a procedure. Leaving behind foreign bodies in the peritoneal cavity constitutes an unfortunate medical error with frequency reported in literature ranging from 1/1000 to 1/15,000 cases [2].

Digestive and gynecological operations account for between 60% and 74% of cases of intra-abdominal textilomas [3] [4] [5]. Elective surgery often responsible in 71% of reported cases [4]. In 60% of cases recorded in literature, the textiloma is a large surgical towel or rarely many towels left behind mistakenly at one or several operating fields [4].

From a pathophysiological standpoint, textilomas elicit two types of inflammatory response. The first is one of aseptic fibrosis leading to the formation of adhesions and encapsulations; resulting in foreign body granuloma, setting insidiously without showing any clinical symptoms. The second is rather an acute

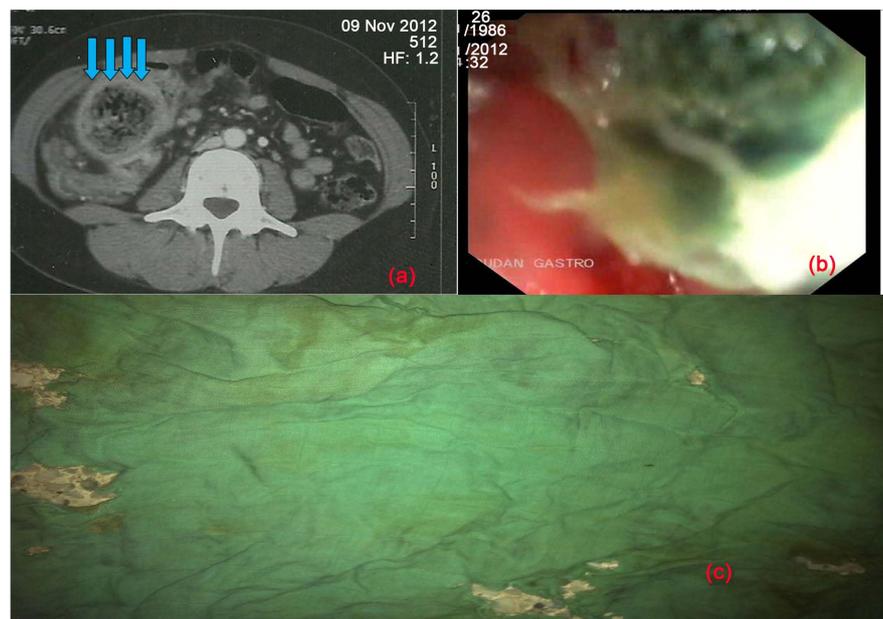


Figure 1. (a) CT scan showing a right iliac fossa mass; (b) Endoscopic image of textiloma; (c) Textiloma after rectal expulsion.

exudative manifestation leading to abscess formation with or without secondary bacterial invasion. In the latter, it may present as abdominal pain, a mass, bowel obstruction, gastrointestinal bleeding, abdominal infection or even peritonitis and in some cases forming fistula with surrounding organs [6].

Retained foreign body detection timeline is variable, ranging from days to several years after surgery [7]. Generally, several clinical presentations have been described previously: abdominal infection, bowel obstruction, GI bleeding, pseudo-tumor forms, fistula forming cases and even asymptomatic ones with incidental findings [4] [5].

Migration of textiloma in the intestinal lumen is considered a rare complication and occurs as a result of inflammation of the intestinal wall leading to necrosis [1]. Few cases have been reported in the literature: a case involving intestinal lumen migration recorded in Japan [8] with Zantvoord *et al.* [1] noting 65 cases in total including one of theirs.

The most common site of impaction is the intestine (75%), and most cases (95.3%) underwent laparotomy to remove textiloma [1]. After complete migration in the intestine, textiloma usually ends up in the terminal ileum, as was the case in our patient where it often leads to small bowel obstruction [9]. On the other hand, cases of spontaneous rectal expulsion of textiloma as in our patient are rarely described [1].

Despite technological advancement in diagnostic imaging the exact location of migrated textiloma is hardly determined by imaging [10]. In our patient, textiloma mimicked a tumor like lesion of the caecum on abdominal CT.

However, textilomas diagnosed late or after complication, present an inherent higher risk with mortality varying between 11% and 35% [3]. Some textilomas have been expelled without tissue damage by natural means. [4]

4. Conclusions

Textiloma is a very rare but serious complication of surgery due to its potential clinical consequences and legal implications. Several circumstances of discovery of retained surgical sponge have been described, yet spontaneous rectal expulsion of textiloma remains exceptional.

The surgical team is not immune to the ethical implications of this medical error that can sometimes jeopardize the life of patients.

Prevention is practically the best way to reduce its incidence. The policy of prevention could be enforced by the surgeon himself during swab counts or through the use of radiological markers and other adjunct technology.

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