Abdominal Textiloma about a Case

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Abstract

In fact, textiloma is a postoperative complication. It is very rare but well-known. Besides, it could be a strange body consists of compresses or surgical remaining field at the level of an operating area. In other words, the discovery of the abdominal textiloma is generally late. Therefore, the history is essential for diagnosis since the clinic isn't conclusive. The clinic combines chronic transit disorders with subocclusive syndromes and the abdomen image which makes the preparation less effective. In addition to that, the ultrasound is reliable. The computed tomography allows an accurate topographical diagnosis. Some teamworkers suggest some explorations concerning the MRI. Thus, we report a case of intra-abdominal textiloma with an operated patient for a cesarean section.

Keywords: Textiloma, abdominal surgery, compresses.

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INTRODUCTION

Textiloma is also called gossypiboma. It is a postoperative complication. It is very rare but well-known. In other words, gossypiboma is derived from the word gossypium which means cotton in Latin and boma means a hidden place in Swahili. It is used to describe a strange body which contains of compresses or remaining surgical fields at the level of an operating focus [1, 2]. Besides, it is a limited complication of abdominal and pelvic surgery, which is difficult to be estimated [2]. We report a case of intra-abdominal textiloma concerning an operated patient in terms of a cesarean section

PATIENT AND OBSERVATION

Mrs. J. Sefouan i is 19 years old, without ATCD; Regular cycles; without contraceptive methods. Pregnancy is followed by the normal course, apart from anemia at 9.9g / dl, Admitted on 07/14/19 in RPM which is done with LAC that goes back 4 hours before the admission.

Admission exam IMC 28 .TA: 09 /05.t: 36.5; with defective hygiene; obstetrical examination: HU: 31 cm; CU-; BCF and reg; bishop at 3; PC / BCN; the vaginal delivery was accepted.

The patient benefited from the 1st trigger at 12 p.m. rupture with failure. At 25 h of rupture the patient spontaneously went into work, the report went from 3 cm to 7 cm after 3 h; on head not engaged, the observation remained unchanged over 2 hours; we concluded that stagnation is ELV.

The ELV took place without any particularity (in the standards with respect for the technique of the caesarean section (hysteroGRAPHY with separate points).

It is Noted that we used a single field placed at the level of the left pariacolic gutter. On D2 of the post-operative period: the patient presented an acute abdomen with loss of materials and gases in a febrile context; whose abdominal examination showed a bloated abdomen.

The diagnosis of peritonitis was retained TDM which carried out objectifying which makes the image evoke a textilome.

The Patient made a surgery on the next day: the exploration of which had effectively identified a textiloma in the left parieto-colic gutter. The post-operative suites were unremarkable.

Fig-1: TDM shows a huge abdominopelvic mass which measures 18 mm of transverse axis on 12 mm arranged in accordion

Fig-2: The extracted operating fields

DISCUSSION

The textiloma is an iatrogenic lesion which has developed around a strange textile body which is forgotten during the surgery. The more academic term of gossypiboma testifies to the inflammatory reaction that induced by a textile body in contact with tissues which results in the formation of an inflammatory granuloma [3]. The reported frequency in the literature is from 1/1000 to 1/10000 [4]. The literature review (117 cases published from 1952 to 1993) which emphasizes the predominance of intraperitoneal textilomas (52%), but other sites are concerned: gynecological (22%), urological and vascular (10%), bone and spinal (6%), miscellaneous (10%) [5]. The diagnosis of textiloma is based on anatomopathological examination.

The Missing equipment remains the surgeon's obsession during any intervention and then the evolution of the patient could be dramatic. In fact, in the literature review by Le Neel *et al.*, [5], the exeresis of the textiloma certainly leads to uncomplicated healing in 70 patients (59.8%), but the complications worsened the course of 25 patients. (21.3%), and 22 patients died (18.9%) Twenty-one of the 22 deaths are attributable to abdominal textilomas and concern symptomatic textilomas recognized late, requiring more aggressive gestures (intestinal resection and / or colic) with a significant percentage of severe complications, particularly septic.

On the pathophysiological level, the textile fibers cause since the 24th hour an inflammatory reaction with exudation that followed by the formation of a granulation tissue (8th day), finally the fibrosis is organized from the 13th day. This evolution explains, in the absence of infection, the possibilities of encystment or even calcifications with a tolerance which sometimes seems long [3].

The discovery of the abdominal textiloma is generally late [6]. Therefore, Anamnesis is essential in the development of the diagnosis. The clinic lacks specificity. It combines chronic transit disorders with repetitive sub-occlusive syndromes, as in our observation. These disorders could be related to the phenomena of digestion of the strange body or to a spontaneous disinvagination. Radiologically, the abdomen radiograph without preparation is not very helpful, as is often the case in pre-occlusive syndromes. The ultrasound is reliable and it shows multiple extra-digestive or intra-lesional air bubbles with no notion of infection. These bubbles correspond to the air embedded in the stitches of a cotton pad or a field. Calcifications are often nonexistent [7].

The Computed tomography allows a precise pre-operative topographic diagnosis. At the same time, it performs a completed exploration of the abdominal cavity in terms of complications (fistulas, pneumoperitoneum, abscess). The teamworkers suggest explorations by MRI [6, 8]. Indeed, the abdominal textiloma can mimic a connective tumor and the small intestine is a frequent localization of the primitive forms of lymphoma.

The counting of compresses and drapes by the surgeon, at the beginning and the end of the intervention remains effective but still insufficient means. In the United States, the use of compresses marked radio-opaque as early as 1940 according to the recommendations of Cr Ossen, which significantly contributed to limit this type of incident [5].

CONCLUSION

In spite of the current advances, caution remains in regard to surgical compresses or operating

drapes on previously operated sites, which may be responsible for pseudo-tumor granulomas, causing significant tissue damage around the strange body accidentally left in place. According to the case and medical law, the discovery of a textiloma is recognized as a fault, which involves the responsibility of the surgeon.

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