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A Compress Forgotten in the Stomach for 17 Years: A Case Report

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Abstract | **Case Report**

Introduction: Hardly a month goes by without a surgical journal publishing a clinical case in which a surgeon has forgotten to place a cotton pad or woven drape in a patient's body, usually in the abdomen [1] The aim was to demonstrate that a compress can remain in the abdomen for a long time without being talked about. ***Patient and Observation:*** We report the result of a clinical observation by Mrs MD, a 42-year-old Guinean merchant, operated on in 1997 in Guinea Bissau at KANTHIOUNKO hospital for a cyst of the right ovary. She consulted our department for abdominal pain. The existence of clinical signs justified systematic exploratory laparotomy to avoid secondary complications. ***Results-Commentary****:* Dissection of the mass revealed an abdominal compress that had remained in the abdomen for 17 years. In particular, chronic cases do not present specific clinical and radiological signs for differential diagnosis. The unprepared abdominal X-ray is of limited value, while ultrasound is reliable. ***Conclusion:*** Counting field compresses and other abdominal surgical material is a safe means of prevention, and the best approach to avoid this type of postoperative complication.

Keywords: abdominal compress kanthiounko gossybipomas laparotomy woven drape.

INTRODUCTION

Hardly a month goes by without a surgical journal publishing a case report of a surgeon forgetting to place a cotton pad or woven drape in a patient's body, most often in the abdomen [1].

We report a clinical observation of a 42-year-old Guinean woman, Mrs MD, who complained of abdominal pain initially localized in the hypogastrium and then spreading to the whole abdomen, accompanied by liquid vomiting, pollakiuria and a sensation of abdominal mass.

The patient had no classical history; the existence of clinical signs justified systematic exploratory laparotomy to avoid further secondary complications.

Textile foreign bodies trigger an inflammatory reaction. This can lead to the formation of an abscess, which will appear rapidly, or to the formation of a fibrous shell. In the latter case, the foreign body may remain invisible for a very long time, with symptoms only appearing after several years [1].

This is an infrequent complication of abdominal and pelvic surgery, which is difficult to estimate [2].

Pathophysiologically, textile fibers provoke an inflammatory reaction with exudation as early as the 24th hour, followed by the formation of granulation tissue (8th day), with fibrosis developing from the 13th day onwards. This evolution explains, in the absence of infection, the possibility of encystment or even calcification, with a sometimes long tolerance [3] as in our observation.

The discovery of abdominal textiloma is generally delayed [4]. The anamnesis is therefore essential in making the diagnosis. Clinical features lack specificity. It associates chronic transit disorders with recurrent subocclusive syndromes [5].

PATIENT AND OBSERVATION

Mrs MD, aged 42, is a merchant of Guinean nationality. She lived in Guinea Bissau from 1995 to 2013.

On her return to Guinea, she consulted us for:

Abdominal pain that initially localized to the hypogastrium and secondarily spread to the entire abdomen accompanied by liquid vomiting, pollakiuria and a sensation of abdominal mass. The patient did not have a classic history.

Past history:
Medical: malaria, undocumented intestinal parasitosis
Surgical: operated in 1997 in Guinea Bissau at KANTHIOUNKO hospital for cyst of right ovary.
Gynaeco-obstetrics: G=5, P=4, A=1 DDR= not clarified
NB: secondary sterility since date of operation

CLINICAL EXAMINATION

Normo sthenic patient in satisfactory general condition.

Inspection reveals a bulge from the lower abdomen to the umbilicus, and a Pfannenstielle surgical scar.

Palpation revealed a hard, mobilizable abdominal mass in relation to the deep plane, slightly irregular with well-defined upper and lateral margins.

The lower border was difficult to appreciate, giving the impression of a predominantly right-sided mass plunging into the pelvis.

Percussion: revealed a dullness
Auscultation: apart from the surrounding intestinal peristalsis, revealed no abnormal sounds.
Pelvic touch:
TV: clean vulva, short permeable median cervix, right lateral cul de sac filled, uterus of appreciable and normal size.
A painless, palpable and mobile right latero-uterine mass. The fingernail comes back clean.
TR: anal margin free; sphincter of normal tonicity, rectal ampulla empty, douglas not bulging and painless finger pad returns clean

Blood pressure= 13/7 cm hg, pulse= 90 beats per minute, temperature= 37^{o}c, respiratory rate= 19 movements per minute.

Examination of the other devices revealed no clinically detectable pathological features.

Overall: we retained an abdominopelvic mass as the diagnosis that could arise from the sequelae of cystectomy of the right ovary.

We sought the advice of a colleague experienced in abdominopelvic ultrasonography, who suggested a right latero-uterine mass.

We decided on the operative indication, preferring a subumbilical median enlarged to 3 cm above the umbilical for a good day, avoiding the old scar.

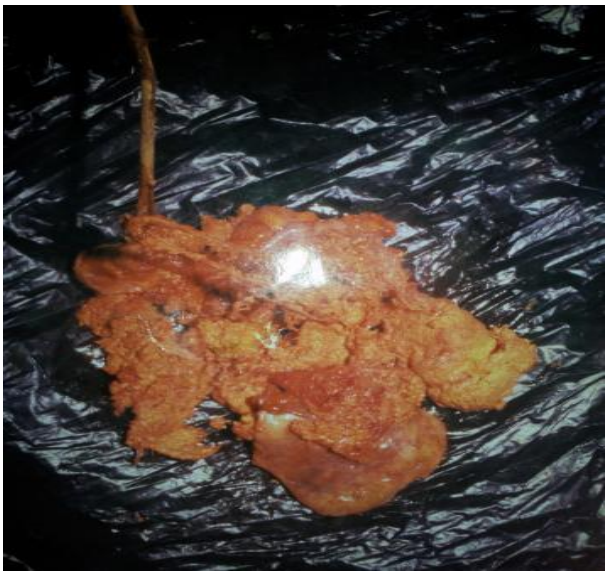
When the cavity was opened, exploration revealed an abdominopelvic mass partitioned by the douglas folds, measuring around 8 to 12 cm by 4 to 6 cm in diameter, independent of the uterus, bladder, ureters, rectum and left adnexa.

The right adnexa was absent, and the other intra-abdominal organs were macroscopically normal.

PROCEDURE: We proceeded with ligation and resection of the pedicle carrying the mass, with control of haemostasis and parietal closure in two dressing planes.

RESULT-COMMENTARY

Before sending the specimen for ana-path, we dissected the mass, which we found to be an abdominal compress.



Textiloma, also known as gossybipomas, is a very rare post-operative complication. It may be a foreign body consisting of surgical pad(s) or drape(s) left behind at an operative site. They are more often asymptomatic, and difficult to diagnose.

In particular, chronic cases do not present specific clinical and radiological signs for differential diagnosis. The history is therefore essential for diagnosis, since clinical signs are inconclusive. The unprepared abdominal film is of little help, while ultrasound is reliable. [6]

In our case, the patient did not benefit from a CT scan due to lack of financial resources, as this would have enabled a precise topographical diagnosis.

Our study confirms the factors classically incriminated in the omission of foreign bodies, which are: emergency surgery, sometimes of long duration and frequently haemorrhagic, performed in a narrow and deep operative field, such as our patient's pelvic surgery; operative difficulties which, by lengthening the duration and modifying the tactics of the operation, blunt the surgeon's vigilance; the lack of experience and discipline of the operators [7].

The frequency of foreign body omissions after abdominal surgery is difficult to establish, as not all observations are reported. However, the authors agree that it is a rare complication, with a prevalence of between 0.1% and 0.2% of procedures.

The checklist is a program that can reduce postoperative morbidity and mortality by up to 30%.

The principle is simple: check a series of criteria considered essential for any surgical operation, and if necessary, trace the decision taken in the event of non-compliance, in order to implement specific improvements. The HAS checklist “patient safety in the operating theatre” has been deployed since January 2010 for all surgical specialties. Today, professionals recognize that it contributes to improving patient safety. However, the checklist does not appear to be fully adapted to all surgical procedures, which involve specific aspects of patient care.

As far as our patient is concerned, it is difficult for us to pinpoint the main cause or factor responsible for forgetting to use the abdominal compress. However, professional recommendations have been issued by various learned societies, both on protocol drafting and on the inventory of factors “favoring” this omission or error. These factors include:

Manufacturer's errors, with the wrong number of compresses being dispensed in relation to the number indicated on the packaging.

- Counting too early for closure.
- Fatigue and relaxation at the end of the procedure.
- Nurse team changes during the procedure.
- Unexpected change in operating procedure.
- Emergency surgery, bleeding...
- High body mass index. [8]

Among the factors incriminated in the forgetting of a compress in the abdomen, the high body mass index was not justifiable, as our patient was normo sthenic and in satisfactory general condition.

In fact, abdominal textiloma can mimic a connective tissue tumor, and the small intestine is a frequent site for primary forms of lymphoma. Textiloma can be confused with colonic adenocarcinoma [9].

Conclusion

Textiloma or gossybipomas can be a serious lesion in abdominal and gynaecological surgery. Counting of compresses, drapes and other abdominal surgical material under the surgeon's supervision at the beginning and end of the operation is the only means of prevention, and is the best approach to avoid this type of postoperative complication.

Our textiloma is secondary to gynaecological surgery and has remained undetected for 17 years.

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References

1. Gozlan. M: Quand un churirgien oublie compresse et autres textiles 21 avril 2017 Jr Med).
2. (O'Connor AR, Coakley FV, Meng MV, Eberhardt SC. Imaging of retained surgical sponges in the abdomen and pelvis. AJR Am J Roentgenol. 2003 Feb;180 (2):481–9.[PubMed] Pan Afr Med J. 2011; 9: 10. Publication en ligne 2011 mai 26. French.)
3. Chambi i, tasker rr, gentili f, lougheed wm, smyth hs, marshall j, young i, deck j, shrubb j. Gauze-induced granuloma (gauzoma): an uncommon complication of gauze reinforcement of berry aneurysms. J neurosurg. 1990 feb;72(2):163-70. Pubmed | google scholar
4. Roumen RM, Weerdenburg HP. MR Features of a 24-year-old gossypiboma: A case report. Acta Radiol. 1998 Mar; 39(2):1768. PubMed | Google Scholar
5. Moyle H, Hines OJ, McFadden DW. Gossypiboma of the abdomen. Arch Surg. 1996 May; 131(5):566-8. PubMed | Google Scholar
6. Driss Erguibi1, Robleh Hassan1 & Mohamed Ajbal1, Bouchaib Kadiri1. Textilome abdominal, à propos d’un cas, 1Chirurgie Viscérale, Service Aile I, Centre Hospitalier Universitaire IBN Rochd, Universite Hassan II, Casablanca, Maroc, Pan African Medical Journal – ISSN: 1937- 8688 (www.panafrican-med-journal.com) Published in partnership with the African Field Epidemiology Network (AFENET). (www.afenet.net) Published: 05/08/2015
7. LEBEAU R, DIANE B, KOFFI E, AMANI A, KOUASSI J.C, LES CORPS ETRANGERS APRES CHIRURGIE ABDOMINALE A PROPOS

DE 12 OBSERVATIONS, Service de chirurgie générale et digestive, CHU de Bouaké, BP 1174 Bouaké, Côte d'Ivoire Tirés à part : Roger Lebeau, 22 BP 139 Abidjan 22, Côte d'Ivoire Tél : 225 05 58 17 25 / Email : lebeauroger@yahoo.fr Mali Médical 2004 T XIX N° 3&4

8. OUBLI DE CORPS ETRANGER INTRA ABDO MINAL, Année 2013, n° 1,http://www.macsf.fr/vous-informer/actes-de-soins-professionnel-sante/lerreur-medicale-professionnel-sante/ oubli-de-compresseresponsabilites.html
9. Rajagopal A, Martin J. Gossypiboma "a surgeon's legacy": report of a case and review of the literature. Dis Colon Rectum. 2002 Jan; 45(1):119-20. PubMed | Google ScholarA.
10. Mathew RP, Thomas B, Basti RS, Suresh HB. Gossypibomas, a surgeon's nightmare-patient demographics, risk factors, imaging and how we can prevent it. Br J Radiol. 2017 Feb;90(1070):20160761.
11. Yakar A, Atacan SÇ, Yakar F, Ziyade N, Gündoğmuş ÜN. Medicolegal consequences of thoracic gossypiboma: A case report. J Forensic Leg Med. 2016 Aug;42:65-7.
12. Hajji F, Ameur A. Gossypiboma. Pan Afr Med J. 2015 Apr 7;20:332.
13. Canelas A, Seco M, Graça B, Cavalheiro F, Curvo-Semedo L, Teixeira L, Caseiro-Alves F, Coimbra PT. Abdominal gossypiboma: A pictorial review. Poster No.: C-395. Congress: ECR 2009. European Society of Radiology
14. Manzella A, Filho PB, Albuquerque E, Farias F, Kaercher J. Imaging of gossypibomas: pictorial review. AJR Am J Roentgenol. 2009 Dec;193(6 Suppl):S94-101.