Gossypiboma

Hadi Mirfazaelian[1], Mansour Ansari[2], Yahya Daneshbod[3]

[1] Department of Emergency Medicine, Tehran University of Medical Sciences, Tehran, Iran
[2] Radiation Oncology Department, Namazi Hospital, Shiraz University of Medical Sciences, Shiraz, Iran
[3] Department of Hematopathology, Dr. Daneshbod Pathology Laboratory, Shiraz, Iran

Study conducted at Tehran University of Medical Sciences, Tehran, Iran

Correspondence to: Hadi Mirfazaelian – Tehran University of Medical Sciences, Department of Emergency Medicine, Tehran, Iran – h-mirfazaelian@razi.tums.ac.ir

A 50 year-old man presented to the emergency department due to abdominal pain. The patient had gastric cancer with regional lymph node involvement. He had had a gasterectomy eight months prior, with several courses of chemotherapy. His history was also significant for his mother's gastric cancer. The patients complained of dull pain mainly in the left upper quadrant without radiation and no aggravating or relieving factors. The pain had been present since the surgery, with no significant increase or decrease. On the radiography, there was a radiopaque shadow of a probable foreign body under the left hemidiaphragm, mostly consistent with a surgical sponge (Figure 1). The patient underwent another operation for surgical sponge removal. He had no complication during follow-up, and later resumed chemotherapy.

Gossypiboma derives from the Latin word *gossypium*, meaning cotton, and the Swahili word boma, meaning place of concealment[1]. It is also named textiloma, gauzoma, or muslinoma. Although the real incidence is not clear, the bare minimum is reported to be one in 5,500 operations[2]. This condition is diagnosed from few weeks after surgery to several years later, mostly by labeling as a new onset tumor, or a recurrent tumor[1]. It is discovered mainly by computed tomography (61%), followed by radiography (35%), and ultrasound (34%)[3]. There are several risk factors for gossypiboma, such as emergency operation, unexpected changes in surgical procedure, and patients with high body mass index (BMI)[3]. While any physician must bear this diagnosis in mind, all efforts must be taken in order to decrease this misadventure.

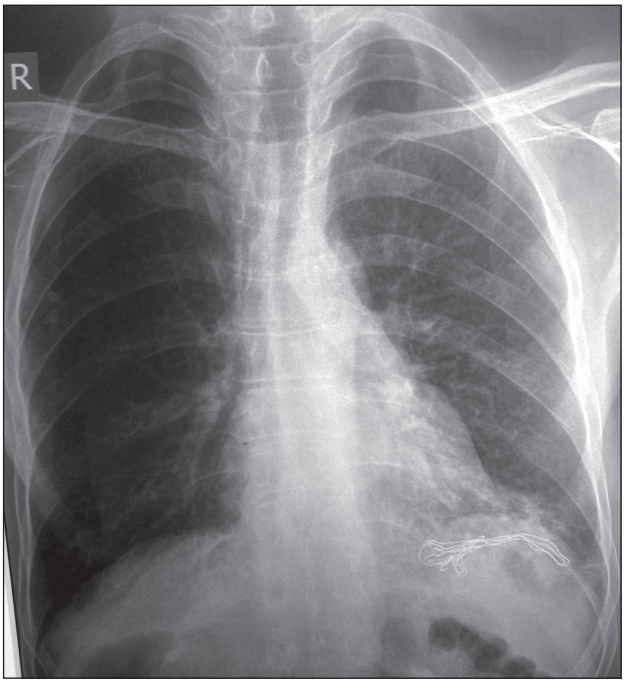

Figure 1 – Radiography showing radiopaque shadow of a probable foreign body under the left hemidiaphragm.

References

1. Kiernan F, Joyce M, Byrnes CK, O'Grady H, Keane FB, Neary P. Gossypiboma: a case report and review of the literature. Ir J Med Sci. 2008;177(4):389-91.
2. Cima RR, Kollengode A, Garnatz J, Storsveen A, Weisbrod C, Deschamps C. Incidence and characteristics of potential and actual retained foreign object events in surgical patients. J Am Coll Surg. 2008;207(1):80-7.
3. Wan W, Le T, Riskin L, Macario A. Improving safety in the operating room: a systematic literature review of retained surgical sponges. Curr Opin Anaesthesiol. 2009;22(2):207-14.