

Same Session Transureteral Lithotripsy and Laparoscopy: A Case of Ureteral Stone with Abdominal Forgotten Gauze after Four Years

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INTRODUCTION

Forgotten or retained surgical gauze or pad in the abdominal or pelvic cavity after an operation is named gossypiboma. The other synonyms for gossypiboma are textiloma, cottonoid, gauzoma and muslinoma.^(1,2) Removal of surgical gauzes or instruments by laparoscopic surgery has already been done and reported.⁽³⁻⁷⁾ Herein, we present a case of abdominal gossypiboma four years after hysterectomy. We performed laparoscopy as the surgical option.

Keywords: laparoscopy; methods; lithotripsy; ureteral calculi; surgery; treatment outcome; abdomen; surgical sponge; foreign bodies.

CASE REPORT

A 53-years-old woman presented with acute right renal colic. After medication and pain mitigation, radiologic investigations were done. A 10-mm stone in the right distal ureter

and a forgotten surgical gauze in the left side of the pelvis were observed on kidney-ureter-bladder (KUB) X-ray and confirmed by intravenous urography (IVU) and computed tomography (CT) scan. The size of foreign body on CT scan was measured 5 × 3.5 cm which has been encircled by the small intestine and the colon. Transureteral lithotripsy (TUL) and Laparoscopy were scheduled.

SURGICAL TECHNIQUE

Under general anesthesia and lithotomy position TUL was performed and calculus particles were removed. There after laparoscopy was settled in supine position with one 12-mm infra-umbilical port and two 5-mm ports in the left and right lower quadrants and the gauze was separated from the surrounding tissues and brought out from the abdomen by an endo-catch bag. The patient was discharged on the fourth postoperative day.

DISCUSSION

Forgetting or leaving gauzes or instruments in the body cavities after any operation is merely iatrogenic and considered as malpractice.^(1,8,9) Gawande and colleagues studied 61 patients. They reported the presence of surgical sponge in 69% of cases.⁽¹⁰⁾ Rodrigues and colleagues described a case of intra-abdominal forgotten ribbon malleable retractor (33 × 5 cm) since 14 years ago.

The incidence of gossypiboma was estimated from 1:8801 to 1:18760 of surgeries by and colleagues.⁽¹⁰⁾ Several risk factors have been reported for leaving sponge and instruments in operation field, including an emergency operation and long duration of operation.^(2,10,11) Some gossypibomas are symptomatic and the others are asymptomatic.⁽³⁾ In any case, it is recommended to be removed surgically or laparoscopically.⁽¹¹⁾

A case of laparoscopic diagnosis and removal of sponge 14 days after surgery was reported also by Singh and colleagues,⁽³⁾ in the meanwhile Olivier and Devriendt described a case of laparoscopic removal of a gauze which had been forgotten in the abdomen of a patient as long as 22 years.⁽⁵⁾

Our case, presented with renal colic and the retained gauze in her abdomen was detected accidentally. After radiologic

studies, we removed the ureteral stone and forgotten gauze in the same session anesthesia, and accomplished both surgeries endoscopically.

CONCLUSION

According to our experience and other reports, it seems laparoscopic surgery can be appropriate option for removal of forgotten pads or instruments, and can be performed in early or delayed diagnosed cases.

CONFLICT OF INTEREST

None declared.

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