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Review Article

Gossypiboma (Retained Surgical Sponge): an Evidence-Based Review -

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ABSTRACT

Gossypiboma is an infrequent but devastating consequence of a human error. Most often, patients present with vague clinical features and the diagnosis is made several years after the initial surgical procedure. Diagnosis of a gossypiboma has important clinical and medico legal implications and therefore, patients must be provided accurate information in an appropriate manner to help them make informed decisions. Prevention of such untoward incidents can be achieved by improving communication amongst members of the operating team and strictly adhering to sponge-counting protocols. Awareness among all general physicians, surgeons and radiologists regarding this important clinical entity is vital to vouchsafe patient safety and prevent unnecessary morbidity.

Keywords: Gossypiboma; Retained Surgical Sponges; Medical Errors.

INTRODUCTION

Gossypiboma refers to a foreign body—a retained surgical sponge—and it is a direct consequence of human error [1]. This term has its roots in gossipium (“cotton” in Latin) and boma (“place of concealment” in Kiswahili) [2]. The first published report of a gossypiboma dates back to 1884 [3]. Since then, many standardized protocols of sponge counting [4] and use of radio plaque sponges [5] have been implemented; however, such mishaps continue to happen even today [6]. Despite the morbidity associated with gossypiboma, this disorder remains an obscure entity within the medical community and most physicians seldom consider it in their differential diagnoses [7, 8]. Here, we provide an evidence-based review of this infrequent—yet clinically significant—entity.

Epidemiology

The exact incidence of this disorder is difficult to determine as it is seldom reported due to its associated medico legal implications [9]. However, estimates based on various retrospective studies suggest that a foreign body is retained in 1 of every 1000 to 1500 abdominal surgeries [10]. For the purpose of this article, a search of Pub Med, Ovid and EMBASE databases was performed using the keywords “gossypiboma” OR “retained surgical sponges” and all publications retrieved were reviewed. Furthermore, all articles referenced in these articles were also manually reviewed. Using this method, we could find 340 cases reported in 254 peer-reviewed publications, which pertained to nearly all surgical specialties including general surgery, cardiothoracic surgery, obstetrics and gynecology, orthopaedics, urology and neurosurgery (Figure 1).

Pathogenesis

Once retained in the body, surgical gauze act as foreign bodies and induce a strong inflammatory response. An infiltrate comprising of polymorph nuclear leukocytes is seen initially followed by a mononuclear infiltrate, which eventually results in the formation of a foreign-body type granuloma [11]. Chronic inflammation leads to proliferation of fibroblasts, production of granulation tissue and deposition of collagen fibres. Over time, a conglomerate mass is formed and dystrophic calcification can occur within it [12]. In certain cases, invasion by a mixture of anaerobic and aerobic bacteria can lead to the formation of a frank abscess [13]. Occasionally, inflammation within the lesion may ‘spill over’ to an adjacent organ and this can result in the formation of a fistula. Rarely, this may even lead to spontaneous expulsion of a retained sponge [14-18].

Clinical features

Patients with gossypiboma often have vague clinical presentations (Table 1) and the diagnosis usually comes as a surprise [79]. Exact clinical symptomatology depends on the site of the retained surgical

sponge. Abdomen, pelvis and thorax have been reported to be the most frequent sites [80]. Patients often present with pain, discomfort, palpable mass or unexplained fever [81]. Irritation of bowel loops, bladder or rectum can lead to vomiting, diarrhoea, hematuria, dysuria, tenesmus and other systemic complaints [82]. Sponges retained within the thoracic cavity can lead to pain and cough [83], while those retained within the cranial cavity can lead to headache, loss of vision or focal neurologic deficits [84]. However, there have been reports of asymptomatic gossypiboma as well [19,21]. As a consequence, the average time interval between the surgical procedure and diagnosis of gossypiboma is approximately 7 years [85].

Risk factors

Retention of surgical sponges and other foreign objects are widely considered as avoidable mistakes [86]. Consequently, such cases often receive extensive media coverage and result in adverse consequences for the health professionals involved [87,88]. The infrequent occurrence of such errors coupled with their under-reporting precludes the identification of predisposing factors [10]. Nevertheless, a systematic review of 254 cases concluded that ‘emergency surgery’ and ‘poor communication’ are the strongest predictors of a retained surgical sponge [85]. Moreover, in nearly all cases, the sponge count is erroneously believed to be correct at the end of the procedure [89].

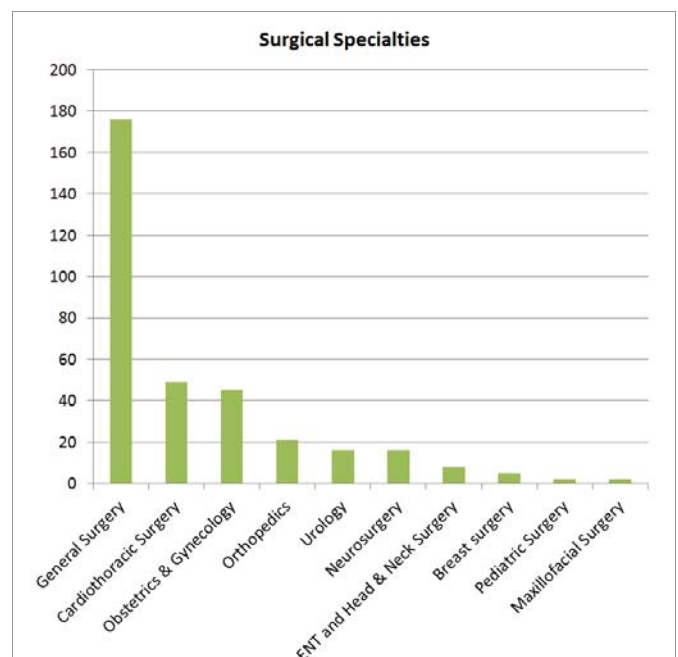


Figure 1: Number of reports of gossypiboma published in international peer-reviewed journals with respect to different surgical specialties.

A single-centre retrospective study of 14 cases also identified ‘obesity’ as a risk factor for retained surgical gauze [90].

Complications

Gossypiboma retained within the abdomen can have numerous adverse sequela. Acute peritonitis can develop as a result of acute inflammation around the retained foreign body [91,92]. Chronic inflammation can lead to the formation of adhesions, which can precipitate intestinal obstruction [29,30]. Inflammation of surrounding viscera can result in the formation of fistulae and migration of the sponge into the lumen [14,15,54,94]. This in turn can lead to intestinal obstruction [95,96] or, in some cases, spontaneous expulsion of the retained sponge [14-18]. Visceral perforation can also occur with resultant secondary peritonitis [36,97]. In rare cases, the retained gauze may transmigrate into the stomach to result



Figure 2: Computed tomography of the abdomen and pelvis demonstrating a mottled lesion in the left lower abdomen with a coiled metallic density (arrows).

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Table 1: Various clinical presentations of gossypiboma

Clinical Presentation	Ref. No.	Clinical Presentation	Ref. No.
Asymptomatic	[18]	Fever of unknown origin	[19]
'Incidentaloma'	[20]	Anemia of chronic disease	[21]
Gastrointestinal			
Biloma*	[22]	Gastric lesion	[23]
Gall-bladder lesion	[24]	Appendiceal tumor*	[25]
Hepatic lesion	[26]	Intestinal tumor*	[11]
Pancreatic lesion	[27]	Intestinal obstruction	[28]
Splenic lesion	[29]	Intestinal polyp*	[30]
Intra-abdominal abscess	[31]	Mesenteric cyst*	[32]
Blumer's shelf†	[33]	Upper GI hemorrhage	[34]
Defecated spontaneously	[15]	Intestinal perforation	[35]
Respiratory			
Tracheal foreign body	[36]	Bronchiectasis*	[37]
Pulmonary nodule	[38]	Tuberculosis*	[39]
Pleural lesion	[40]	Recurrence of lung cancer*	[41]
Diaphragmatic abscess	[42]	Mediastinal mass	[43]
Cardiovascular			
Cardiac mass	[44]	Pericardial lesion	[45]
Recurrent syncope	[46]		
Genitourinary			
Perinephric abscess	[47]	Renal neoplasm*	[48]
Bladder outflow obstruction	[49]	Bladder neoplasm*	[50]
Acute urinary retention	[51]	Bladder stone*	[52]
Ureteroappendiceal fistula	[53]	Per vaginal bleeding	[54]
Testicular lesion	[55]	Spontaneous per-urethral extrusion	[56]
Ovarian lesion	[57]		
Neurological			
Spinal mass	[58]	Paraspinal abscess	[59]
Paraspinal tumor*	[60]	Lumbar abscess	[61]
Psoas abscess	[62]	Chronic lumbago	[63]
Intracranial tumor*	[64]		
Musculoskeletal			
Lesion of hip	[65]	Lesion of knee	[66]
Tumor of femur*	[67]	Non-healing sinus on leg	[68]
Recurrent thigh lesion	[69]	Shoulder abscess	[70]
Soft tissue sarcoma*	[71]	Pathologic fracture of femur	[72]
Lesion of mandible	[73]		
Other			
Neck mass	[74]	Salivary fistula	[75]
Abdominal wall lesion	[76]	Nasoethmoidal lesion	[77]

* Gossypiboma misdiagnosed as this disorder.
 † A lesion in the pouch of Douglas, which is palpable on digital rectal examination as a 'shelf.'
 GI = Gastrointestinal; Ref. No. = Reference number as given in the list of references.



Figure 3: Intraoperative picture of a lump adherent to bowel loops with a gossypiboma visible inside.

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in upper gastrointestinal bleeding [35], or erode the bladder wall to precipitate bladder outflow obstruction [98]. Few incidents of Ureteric obstruction with proximal hydro nephrosis have also been reported in the literature [99].

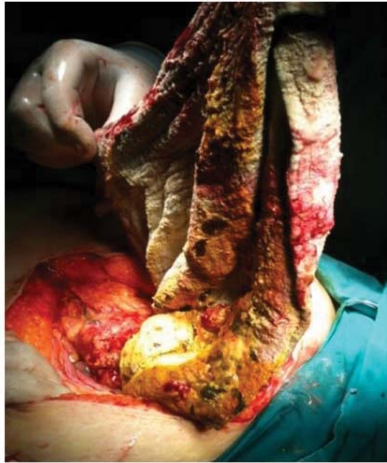


Figure 4: Intraoperative picture of a retained sponge removed after exploratory laparotomy.

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Reproduced from: Colak T, Olmez T, Turkmenoglu O, Dag A. (2013) Small Bowel Perforation due to Gossypiboma Caused Acute Abdomen. *Case Rep Surg.* 2013; 219354. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Diagnosis

Diagnosis of gossypiboma is often difficult to make and requires a high index of suspicion [100]. In patients presenting with a long-standing history of vague symptoms, the possibility of a gossypiboma must be kept in mind [101,102]. During history taking, it is important to establish the chronology of symptoms and whether they relate to a particular surgical procedure [81]. Equally important is to inquire about the patient's past surgical history and specifically regarding the nature of surgeries (i.e. Elective or Emergency). A focused physical examination must be performed to exclude other pathologies. Imaging modalities, especially CT and magnetic resonance imaging, can accurately delineate the lesion and identify its characteristic features [38,103-106]. Most often, gossypiboma appear as spongiform lesions with mottled lucencies and gas bubbles [107,108]. On a CT scan, a characteristic pattern of calcification can be noted along the architectural network of a surgical sponge—the “calcified reticulate rind” sign [109]. Moreover, gossypiboma present within the bowel result in the formation of prominent longitudinal folds, which are visible on a wide range of window settings on a CT scan; this is termed the “stretched faces” sign [110].

Management

Once a gossypiboma is suspected based on clinical presentation and radiologic findings, the first and foremost step is to inform the patient clearly regarding what has happened and how it can be rectified. Cooperation between the primary physician, radiologist and a surgeon can help streamline patient care and allow the patient take an informed decision. The treatment in all such cases is surgical removal of the retained foreign object [111]. Pathologic evaluation of the resected specimen is warranted to confirm the diagnosis and exclude other pathologies [112].

Prevention

Gossypiboma is a direct consequence of human error and extensive research has been conducted on the prevention of this iatrogenic disorder. Sponge-counting protocols [4] and use of radiopaque sponges [5] have been implemented across the globe in this regard. However, cases of gossypiboma still occur [6] and this has led to the development of several other strategies. Sponges with radiofrequency identification tags have been devised, which can be detected automatically by a machine, thereby removing the ‘human’ element in the process [113-115]. Bar-coding of surgical sponges has also been tried, which also shows promise for reducing the incidence of such errors [116]. Some preliminary decision-analytic models have even demonstrated the feasibility and cost-effectiveness of these measures [117]. However, these technologies are still in their incipient stages and their implementation across the globe will only be possible if they are able to stand the test of time. As of now, sponge counting is often mentioned as the “gold standard” for prevention of gossypiboma.

CONCLUSION

Gossypiboma is an infrequent but devastating consequence of a human error. Prevention of such untoward incidents is far better than cure and can be achieved by strictly adhering to sponge-counting protocols and improving communication amongst nurses, technicians and surgeons. At the same time, awareness among all general physicians, surgeons and radiologists regarding this important clinical entity is vital to vouchsafe patient safety and prevent unnecessary morbidity.

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