

Objective

A retained surgical swab “gossypiboma” is an uncommon complication of surgery which can lead to numerous negative outcomes. Our case report is that of a 31-year-old Para 1 lady who had a retained surgical swab following an emergency caesarean section and was misdiagnosed on different imaging modalities as having a necrotic fibroid 2 years later. This case highlights the challenges of imaging modalities in making this diagnosis.

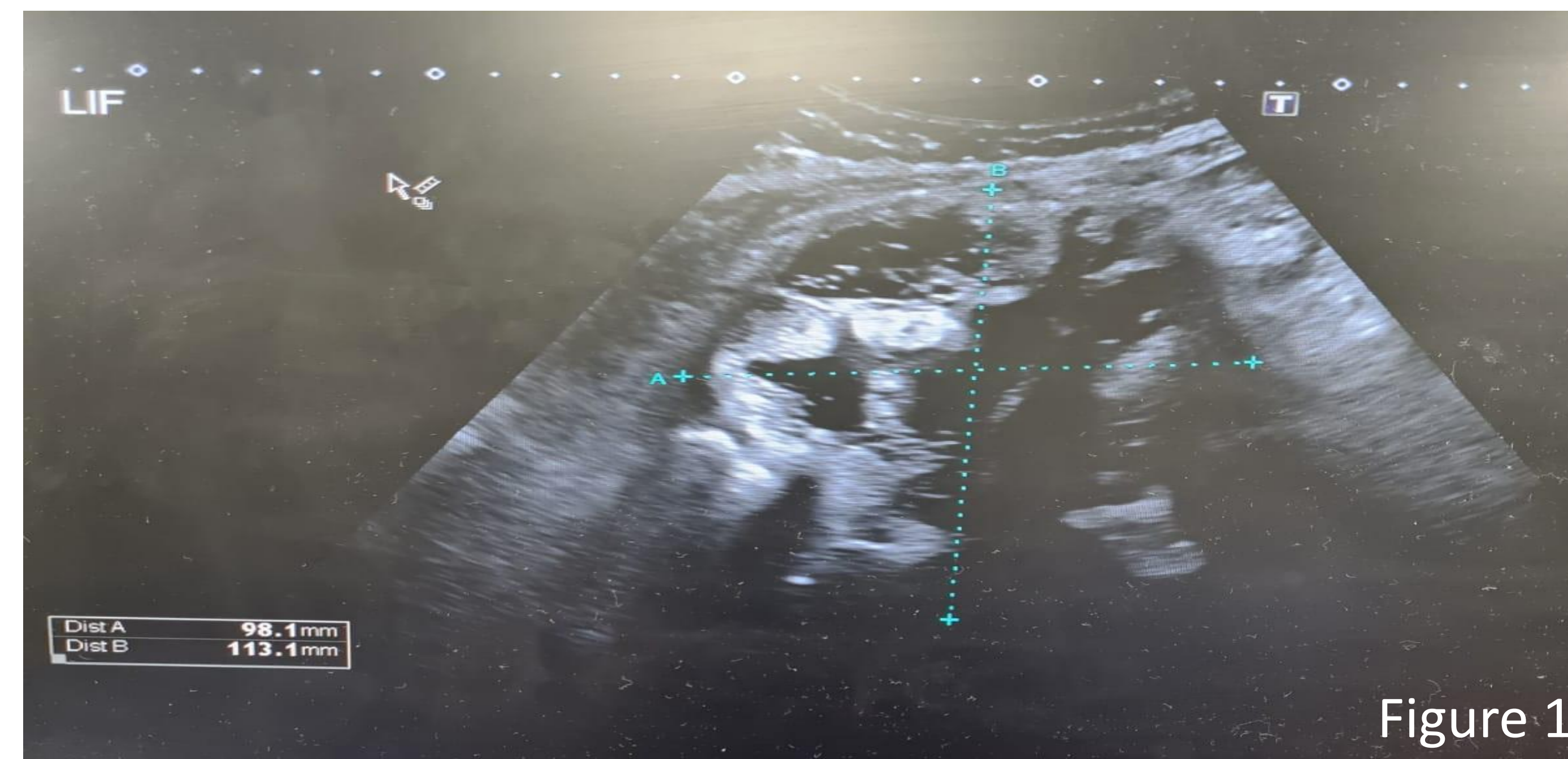


Figure 1

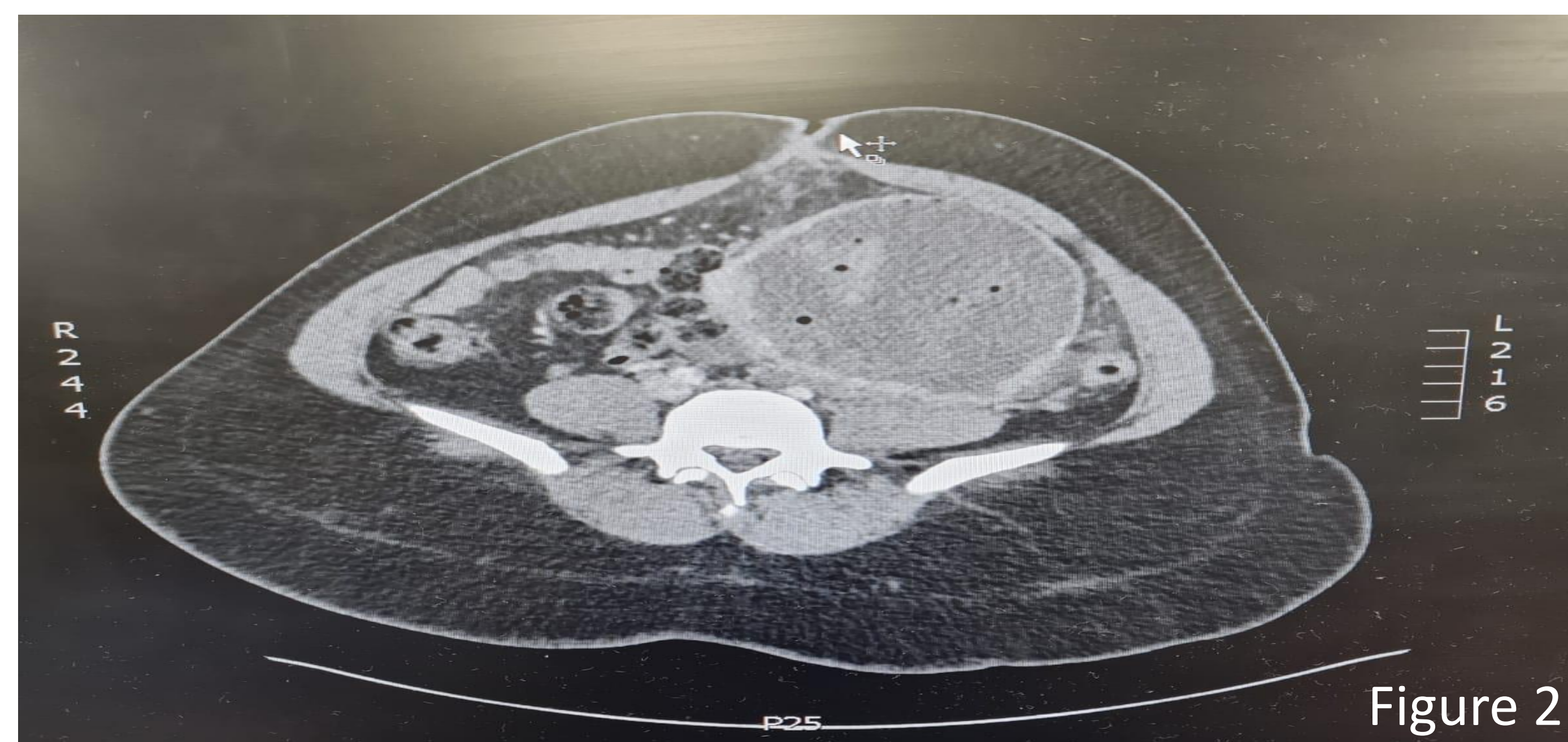


Figure 2

Case Report

Patient was a 31 year old para 1 lady who had multiple presentations to the gynaecology department with left iliac fossa pain. She had 3 admissions over 4 months. Patient had a history of 1 emergency caesarean section outside the UK 2 years ago. Examination showed a tender firm mass in the left iliac fossa. Observations and bloods were normal. Her imaging showed the following:

- **Ultrasound scan:** 12cm mass in the left iliac fossa suggestive of left sided dermoid cyst (figure 1).
- **CT scan:** left iliac fossa /pelvic lesion with appearances of abscess rather than malignancy. Appearances suggestive of tubo-ovarian abscess (figure 2).
- **MRI:** 9.4cm thick-walled cystic structure within the left lower abdomen, suggestive of a tuboovarian/para-ovarian abscess with possible torsion and rupture into the peritoneal cavity (figure 3).

Radiology MDT concluded it was a necrotic fibroid. She subsequently had laparotomy, omental adhesiolysis, division of scar tissue, removal of retained swab, excision of swab cavity and partial excision of left fallopian tube (figure 4).

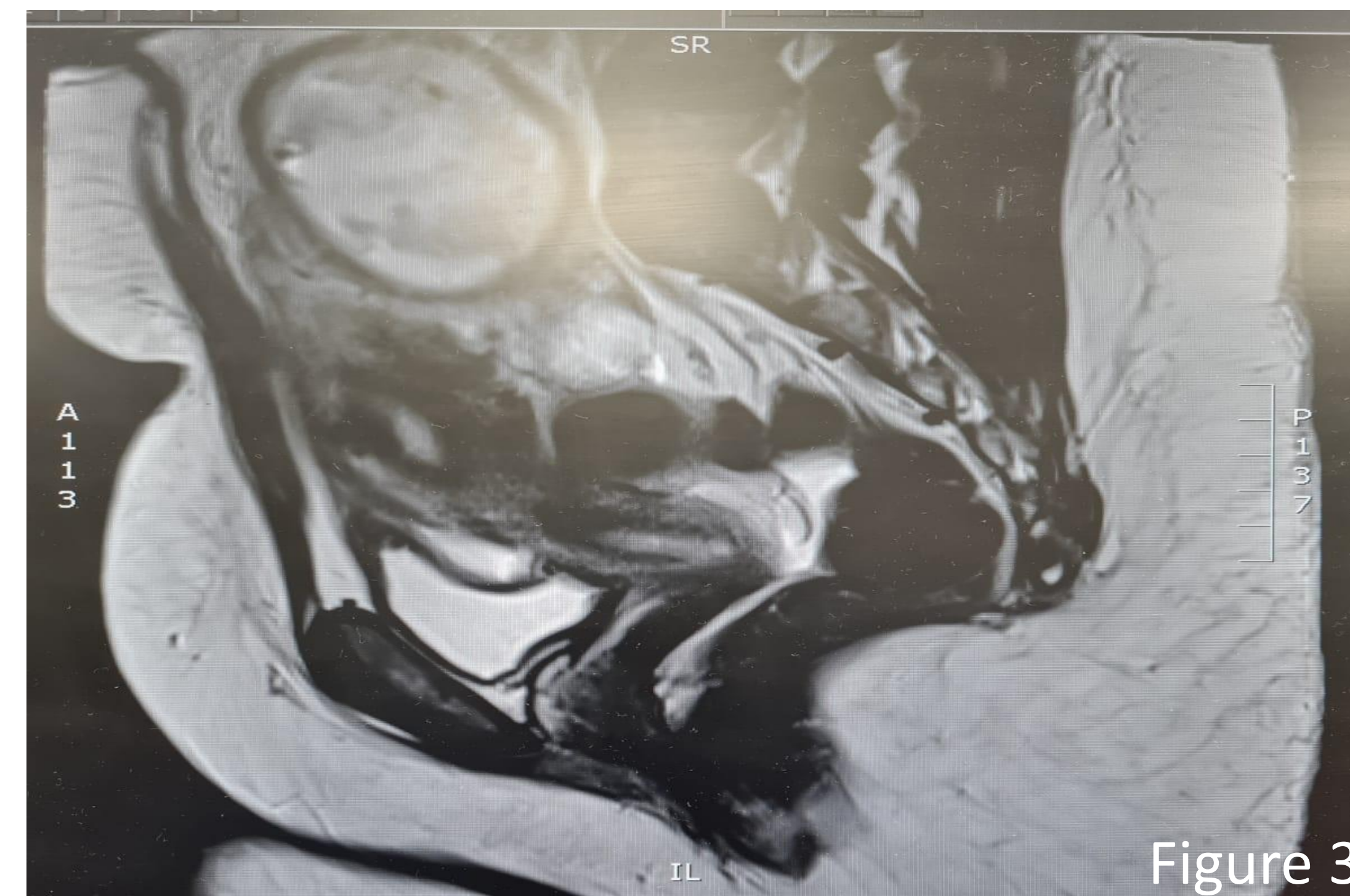


Figure 3



Figure 4

Discussion

Gossypibomas are “never events” and NHS England defines it as a serious, largely preventable patient safety incident that should not occur if healthcare providers have implemented existing national guidance or safety recommendations¹. When swabs are retained, they can lead to repeated infections, hospital admissions and litigations. She had different imaging modalities including ultrasound scan, CT scan and MRI and none of them identified the gossypiboma. This therefore emphasizes the need for prevention as imaging modalities cannot always be relied on to make the diagnosis prior to surgery.

Conclusion

Counting of swabs before closing the abdomen, teamwork, radiography (Xray) and new technologies such as barcode or RFID (radiofrequency identification) labelling of swabs have been found to be important in reducing the occurrence of retained surgical swabs during surgeries^{2,3}. This has a huge impact on patient safety and reduces the need for further surgical interventions with its attendant consequences.

References

- 1) NHS England NHS Improvement. Provisional publication of never events reported as occurring between 1 April 2018 and 31 March 2019. Lond: NHS Improvement 2019.
- 2) Feldman DL. Prevention of Retained Surgical Items. Mt Sinai J Med. 2011 Nov-Dec;78(6): 875-871.
- 3) Weprin S, Crocerossa F, Meyer D, Maddra K, Valancy D, Osardu R, Kang HS, Moore RH, Carbonara U, Kim F, Autorina R. Risk factors and preventive strategies for unintentionally retained surgical sharps: a systematic review. Patient Saf Surg. 2021 Jul 12; 15(1):24.