

CASE REPORT

AN INTRA-ABDOMINAL FOREIGN BODY FOUND 11 YEARS AFTER SURGERY: A RARE CASE REPORT

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ABSTRACT: A retained foreign body in the abdominal cavity following surgery is a continuing problem. Incidence of such accidental revelation of intra-abdominal foreign body reported in the literature is 0.3-1 %¹.

KEYWORDS: Foreign body, Allis forceps.

INTRODUCTION: The problem of retained surgical foreign body has existed ever since humans have first have performed surgical procedures. Various such cases have been reported in the past. One such case was reported in the surgical department of SIMS &RC, SHIMOGA in the year 2009.

CASE REPORT: A 42 year female patient presented to our surgical outpatient department with complaints of pain abdomen, burning micturition and loose stools .On eliciting detailed history we found out the patient was apparently alright 3 years back following which she developed pain abdomen insidious in onset, situated in the lower abdomen, moderate degree, dull aching type which increased on working and relieved on taking medication with no diurnal variation and no positional variation, pain was not associated with intake of food and there was no shifting or radiation. She also complained of intermittent burning micturition since 2 years, which is not associated with pain or blood stained urine.

Patient gave history of intermittent episodes of loose stools from past 1 year, about 4-5 times per day, greenish in color scanty amount, not blood stained. There was no history of vomiting, fever, hematuria, hematemesis, loss of appetite, loss of weight, white discharge per vaginum. Patient gave a past history of repeated hospital visits for similar complaints and was treated on OPD basis by local practitioners. Patient gave past surgical history of LSCS 16 years back and tubectomy 14 years back.

On general examination the patient was pale. Her vital signs were stable. There were no other positive signs on general physical examination.

On inspection of the abdomen, we noted the following findings: a linear scar measuring 6 cms, 4 cm below the umbilicus in the midline. On palpation Abdomen was soft and Tenderness was present over suprapubic region. No organomegaly, no mass felt .Abdomen was resonant to percuss. Bowel sounds were heard.

We proceeded with routine investigations which were within normal limits, USG abdomen revealed a bladder calculi measuring 3.3x 2cms. X-ray KUB REGION to our great surprise showed a radio opaque surgical instrument most probably allis forceps [shown in fig1]. A repeat USG was done and yet there were no comments regarding the foreign body.

The patient was prepared and taken up for surgery. Laparotomy was done and an allis forceps was found. One handle of the forceps was found in the bladder around which there was calculus formation. The other part of the forceps was found in the caecum. The calculus along with

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the forceps was removed and caecum was repaired. The post-operative period was uneventful. Follow up was done for 3 weeks post discharge and patient was symptom free.

DISCUSSION: While no body cavity is spared from the occurrence of RSFB [retained surgical foreign body], anatomical locations that most often house retained surgical foreign bodies are the abdomen, the retroperitoneum, and the pelvis²⁻⁴. In fact, the abdomen and pelvis account for well over half of all RSFB^{2,4}. The consequences of abdomino-pelvic and retroperitoneal RSFB include sepsis, abscess, fistula formation, intestinal obstruction, and even death^{5,6}. Asymptomatic mass suspicious for an abscess or a soft tissue tumor and incidental RSFB finding on radiograms have also been described as presenting features of RSFB in the abdomen, pelvis, and retroperitoneum^{2,7,8}. The presence of RSFB may necessitate reoperation for treatment of complications and/or retrieval of the RSFB^{5, 6}. In addition, complications of RSFB may take many years to develop¹.

One such rare case of retained surgical foreign body is presented above.

CONCLUSION: Retained surgical foreign bodies continue to be a serious problem that affects the entire healthcare system– patients, practitioners, and hospitals. Currently, there are no known methods of completely preventing RSFB. However, the increasing knowledge of risk factors for RSFB, the use of modern technology (i.e., radio-frequency tagging of surgical sponges), and better perioperative patient processing systems (improved surgical team communication, multiple “checks and balances”) may ultimately help minimize the incidence of retained surgical foreign body.

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Fig. 1: X-ray showing the foreign body

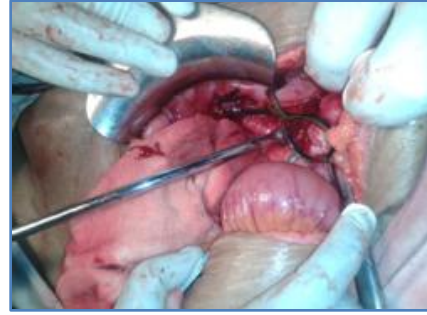


Fig. 2: Intraoperatively recovered surgical foreign body



Fig. 1: Foreign body recovered along with calculus formation

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