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Case Report

Intraluminal Digestive Textiloma: Two Case Reports

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Abstract: Intraluminal textiloma is caused by the retention of surgical textile material in the digestive tract (compress, drape). Textiloma is found intraluminally due to an inflammatory process that causes necrosis and progressive passage of the material through the digestive tract wall. It can be found anywhere along the digestive tract, from the stomach to the colon. The symptoms are not very specific and vary from transit disorders to intestinal obstruction. Morphological examination is frequently used to make a diagnosis. The treatment depends on the locasation and consists of textiloma extraction. We present two (2) clinical aspects of postoperative digestive intraluminal migration of an abdominal field following digestive surgery in this study. The extremely rare nature of these two cases, as well as the diagnostic errors and management methods of this postoperative complication, prompt us to discuss them.

Keywords: Textiloma, surgery, entectomy, fibroscopy.

INTRODUCTION

Textiloma, also known as "gossypiboma," is an uncommon postoperative complication [1]. Gossypiboma is a term derived from the Latin words gossypium, which means cotton, and boma, which means hiding place in Swahili. It is a foreign textile body (compress, drape) that has been left at a surgical site. Its occurrence is greatly reduced by operating room safety measures and the resulting medico-legal implications, but it is a well-known entity among surgeons [2]. When compared to intraperitoneal localisations, intraluminal localisation in the digestive tract is rare and requires a long period of evolution [3].

OBSERVATION 1

This is a 43-year-old patient who was operated on five months ago for peritonitis caused by perforation of a duodenal bulb ulcer by midline laparotomy and who presented to the structural emergency reception service for a three-day stoppage of matter and gas evolving. The general examination reveals a patient in good general condition with a blood pressure of 135/85 mmHg, a pulse of 80/min, and an ambient air saturation of 98%.

The physical examination finds a patient presenting with a distended, tympanic, and sensitive abdomen as a whole; one can palpate a mass at the level of the left para-umbilical region. The biological evaluation is unspecific, with a correct hemoglobin of 15 g/dL, no ionic disorder, and a PT of 100%. a face-standing PSA that showed fluid levels and calcium tone opacity (Fig 1). An abdomino-pelvic CT scan was done urgently and showed a mechanical occlusion on a flange in the left iliac fossa and the umbilical region with visualization of spontaneously dense intraluminal material in the small intestine (Fig. 2). The need for surgical exploration by laparotomy is urgent. The patient is quickly transported to the operating room. The operation consisted of an iterative midline laparotomy straddling the umbilicus, exploration that found a multi-adherent abdomen, and distension of the small intestine upstream of an intraluminal obstacle located 90 cm from the Bauhin valve. Performing an enterotomy, downstream of the loop, allowed the extraction of a surgical white field (Figs 3 & 4). The extracted field was sent for an anatomopathological examination, which confirmed the lymphoma. The post-operative follow-up was simple; the patient resumed transit after two days. Discharge was authorized on postoperative day 5. It was reviewed seven and thirty days after its initial release.

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Figure 1: Standing ASP showing calcium tone image

Figure 2: Axial CT scan showing an intraluminal EC

Figure 3: Enterotomy 80cm from the Bauhin valve

Figure 4: Extraction of the surgical field through the enterotomy

OBSERVATION 2

A 37-year-old well-adjusted patient who had cholecystectomy by right subcostal laparotomy 9 months prior presented to the emergency department for treatment of repeated vomiting. According to the anamnesis, the symptoms began three months ago with the onset of digestive disorders characterised by late postprandial vomiting, which then became early. The general examination revealed that the patient's general condition had deteriorated moderately, as evidenced by asthenia and unquantified weight loss. She has a blood pressure of 127/82 mmHg, a pulse rate of 90 beats per minute, and she is completely saturated with ambient air. Epigastric tenderness is a sign of poor physical examination. The biological evaluation reveals an ion disturbance, with hypokalaemia of 2.9 and hyponatremia of 130. Lipase levels are normal. There is no such thing as a biological inflammatory syndrome. A gastric wall tumour was suspected after an urgent abdominal scan (Fig 5). In emergencies, an esophagogastroduodenal fibroscopy for a biopsy is performed after the correction of hydro-electrolyte disorders, which highlighted a green field at the gastric level and allowed its extraction (Figs 6 & 7).

Figure 5: CT scan axial section showing a gastric pseudotumor

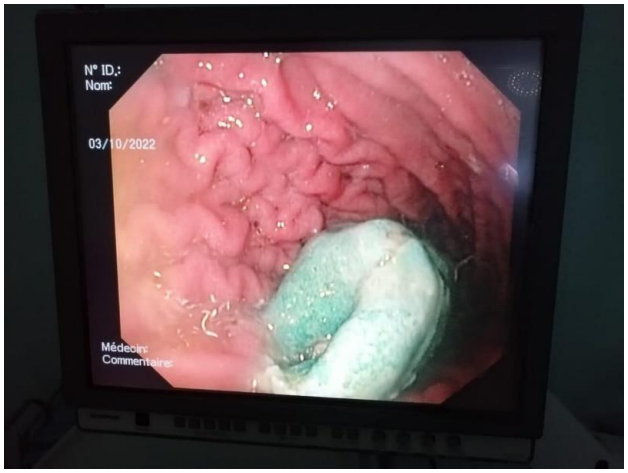

Figure 6: Image of gastric fibroscopy showing an operating field after intragastric migration

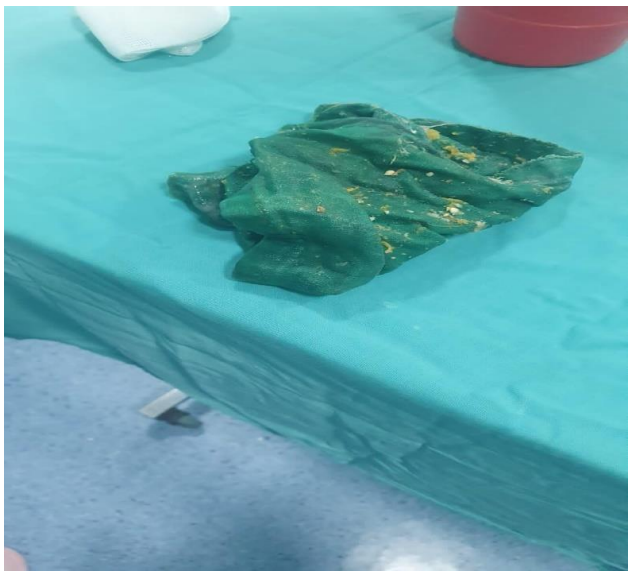

Figure 7: Surgical field extracted by fibroscopy

DISCUSSION

Forgetting a foreign body during a surgical intervention remains the fear of the surgical team, whose vigilance can be disturbed by several factors, dominated by emergency interventions, intraoperative bleeding, obesity, and the unexpected change of procedure. The first case of textiloma was reported by Wilson in 1884 [4], and since then isolated cases or short series have been reported [3]. They are mentioned in all types of surgery, with a focus on abdominal and pelvic surgery [4]. Gynecological interventions are found in some series, with an incidence of more than 50% [4]. The human body tends to eliminate foreign bodies from the body, in some cases by fistulization through natural gastrointestinal or urogenital orifices. The presence of anaerobic bacteria causes local pressure of the foreign body on the necrosis and the fibrous inflammatory response, which has a tendency to cause ensistment [5]. The progression of the compress towards the terminal ileum is favoured by intestinal peristalsis. A long history of abdominal pain, acute intestinal obstruction, or tables of deep suppuration are some of the clinical manifestations, which can be manifested by a long history of abdominal pain, acute intestinal obstruction, or tables of deep suppuration. The two patients in our study had a variety of symptoms; the first had an occlusive syndrome, and the second had an iterative table of vomiting related to their ileal and gastric localization.

The diagnosis of textiloma can be made on radiography of the abdomen without preparation by the demonstration of an opaque intra-abdominal structure, which is more easily recognisable when the compress or the drape is marked. This accounts for the advantage of using marked compression [6]. Computed tomography confirms the diagnosis and allows for precise intraoperative topography. At the same time, she carries out a complete exploration of the abdominal cavity in search of complications (fistulas, pneumoperitoneum, and peritonitis). Some teams provide MRI explorations [6]. Indeed, the abdominal tissue tumour can mimic a connective tissue tumour and the intestine. In our study, only one patient underwent a standing ASP assessment, which showed a metallic-looking foreign body. The

scanner confirmed the diagnosis. Our second patient had an abdominal scan from the outset, which suspected a gastric tumour, hence the realisation of an upper digestive fibroscopy with a double diagnostic and therapeutic interest. The reference treatment for textilome occlusions is enterotomy and extraction of the textiloma [7]. As was the case with one of our patients, our study demonstrates the importance of upper endoscopy for both diagnostic and therapeutic purposes. In cases of colonic location, rare cases of anal expulsion have been described [8].

The surgeon's greatest concern during any intervention is forgetting material, which can have catastrophic consequences for the patient. In fact, according to the literature review conducted by Le Neel *et al*., [9], the excision of the textiloma resulted in healing without complications in 70 patients (59.8%), whereas complications exacerbated the progression in 25 patients. (21.3%), and 22 patients died (18.9%). Twenty-one of the twenty-two deaths were attributable to abdominal textilomas and involved symptomatic textilomas diagnosed late, necessitating more aggressive procedures (intestinal and/or colonic resection) with a significant proportion of severe complications, especially septic [9]. After surgery and endoscopic extraction, our two patients progressed well.

CONCLUSION

The surgeon's greatest fear during any intervention is forgetting material, and the outcome for the patient can be disastrous. Indeed, in the literature review by Le Neel *et al*., [9], the excision of the textiloma certainly led to healing without complication in 70 patients (59.8%), but the complications worsened the evolution in 25 patients. (21.3%), and 22 patients died (18.9%). Twenty-one of the 22 deaths were attributable to abdominal textilomas and concerned symptomatic textilomas recognised late, requiring more aggressive procedures (intestinal and/or colonic resection) with a significant percentage of severe complications, in particular septic [9]. Our two patients progressed well after surgery and endoscopic extraction.

Ethical aspects: The patient's consent was obtained for the use of his data for possible publication. We strictly respect anonymity and no image allows the identification of the patient.

Contribution of the authors:

All authors have contributed to the development of the work. All authors also declare that they have read and approved the document.

Conflicts of Interest: The authors declare no conflict of interest

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