

PHOTO QUIZ

A 52-Year-Old Woman with a Palpable Abdominal Mass

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Figure 1: Axial view of patient's abdominopelvic computed tomography.

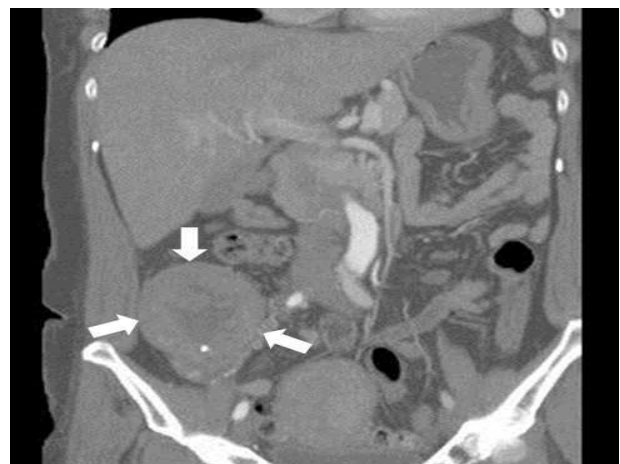


Figure 2: Coronal view of patient's abdominopelvic computed tomography.

Case presentation:

A 52-year-old woman was presented to the emergency department with complaint of unspecific abdominal pain and a 2-week hypermenorrhea. The patient did not have nausea, vomiting, fever, or any other symptoms. She had a history of diabetes mellitus for which she was under medical treatment, and a surgical history of a cesarean section 20 years ago. On arrival, she was vitally stable. Her blood pressure was 120/68 mmHg, with a heart rate of 82 beats/minute and a respiratory rate of 20 breaths/minute. She was afebrile. Her abdominal examination revealed a lower segment cesarean section scar, lower abdominal fullness and a round

mobile palpable mass in right lower quadrant. Bowel sounds were normal. Physical examination of all other parts did not show any positive findings. Complete blood cell count and biochemistry profiles were requested and all were reported in normal range. Carcinoembryonic antigen (CEA) as well as alpha-fetoprotein were also normal. The patient underwent abdominopelvic computed tomography (CT), the results of which are shown in Figure 1 and Figure 2.

What is your diagnosis?



Diagnosis:

Abdominopelvic CT revealed an 8×7×6 cm round well-defined soft tissue mass containing cystic and solid components in the lower right abdominal area, suggesting a gynecologic tumor. A surgical resection of the tumor was performed, and the macroscopic pathological study revealed a gossypiboma inside the mass with a foreign body reaction.

Case fate:

With concern of right ovarian carcinoma, she underwent an exploratory laparotomy. An encapsulated sponge surrounded by omentum was removed. The patient had an uneventful postoperative recovery and was discharged two days later.

Discussion:

Retained surgical sponge or gossypiboma, is an infrequent but serious surgical complication that may lead to significant medicolegal problems (1, 2). The incidence of retained foreign bodies following surgery has a reported rate of 0.06% to 0.1%. However, as gossypiboma is asymptomatic in many patients, its incidence is often underestimated (3). Gossypibomas are most frequently discovered in the abdomen but also reported in other parts of the body (4). It can be a challenging diagnosis due to the wide range of presentations. The clinical presentations vary and depend on location and size of the foreign body. Inflammatory body reaction, including exudative and aseptic fibrous, can also affect its manifestations (3, 5). In our case, the natural evolution of a retained sponge caused a foreign body reaction to form a foreign granuloma that mimicked a soft tissue neoplasm. Gossypiboma in the abdomen can be misdiagnosed as mass or cyst (5). The clinical presentation may present as acute or chronic abdominal pain, abscess formation, fistula formation, perforation, intestinal obstruction or bleeding (6). Diagnosis of the gossypiboma can be made by various imaging methods such as x-ray, ultrasonography (US), CT, magnetic resonance imaging (MRI) or fluorodeoxyglucose positron emission tomography (FDG-PET) (3, 7, 8). However, generally CT is recommended as the best option for this purpose in suspected cases. The CT radiographic features of abdominal gossypibomas include low-density mass with a thin enhancing capsule and spongiform appearance with gas bubbles (9, 10). Operative removal of the foreign body must almost always be performed along with treating its complications. There are some case reports for other options such as colonoscopy (11-13).

Conclusion:

A high index of suspicion is needed to diagnose gossypiboma. Retained foreign body should be in the differential

diagnosis of patients with a history of previous operation.

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