



## IMAGING IN GOSSYPIBOMA

## Neurology

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## ABSTRACT

Gossypiboma is rare. The imaging findings, though characteristic, are subtle. Radiologists need to be well versed with the imaging appearances on different modalities. The same are detailed herein and we discuss how Gossypiboma can be diagnosed and the preventive steps that surgeons need to be aware of. A 30 years old female presented with long standing symptoms of abdominal lump and pain, confirmed by imaging to be a gossypiboma.

## KEYWORDS

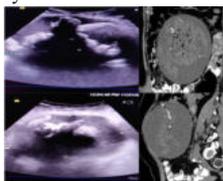
## INTRODUCTION:

Gossypiboma is a rare case but it is a serious condition with medico legal implications. It is an iatrogenic condition which can be totally avoided. It is advisable that surgeons and the nursing staff count cotton or gauze pieces used in surgery such that no residue of that cotton or gauze is left inside the body of the patient. If left behind inside the body cavity then the implications are grave for both patient and surgeon. Patient may develop abdominal lump, chronic pain, adhesions, fistulae and sinuses. When a patient with a previous history of abdominal surgery comes to the hospital with complaints related to the abdomen such as pain, vague lump, constipation etc, Gossypiboma should always be considered as a differential. Usually, the diagnosis is made by subtle findings on imaging, after excluding common conditions. As this may take some time, the patient is likely to have prolonged morbidity. Imaging such as radiographs, ultrasonography, CT scanning and PET are useful in making diagnosis even if the culprit gauze has no radiopaque material.

**Clinical details:** A 30 years old female presented with pain abdomen, palpable central abdominal lump and frequent episodes of constipation for about a month. There was no history of anorexia or weight loss. Patient had undergone laparotomy 5 years earlier for gynaecological indication; no records of previous illness or treatment were available.

## DISCUSSION AND CONCLUSION:

Patient was referred to the Radiology department for ultrasonography which showed an echogenic, thick, roughly linear structure in the central abdomen, appearing as a heteroechoic lesion of size 8.9cm x 10.5cm x 15cm with minimal interbowel free fluid. On CT scan, there was a non enhancing, heterogeneously hypodense lesion of size 10.2cm x 12.5cm x 14.9cm with few foci of air and a curvilinear hyperdense structure within. Often, as is evident in the case presented herein, the mass is adherent anteriorly to the peritoneum and may occasionally even rupture externally. Abdominal ultrasound scans, coronal and sagittal sections of NCCT abdomen, as seen in attached figure, were diagnostic of Gossypiboma as along with pockets of air trapped in the surgical sponge there was the radio-opaque marker thread interwoven in surgical sponges. Operating team, nursing staff and physicians need to carefully count the surgical sponges used during every operation immediately prior to closure of the abdominal wall and also post procedure to make doubly sure that all surgical sponges have been accounted for. If in doubt, an abdominal X Ray can be taken which would show the radio-opaque marker thread within the surgical sponge. Imaging findings as described above are confirmatory for a retained sponge in the appropriate setting. These cases have often led to physician -patient litigation and therefore are important to be highlighted periodically.



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