FORGOTTEN SWAB IN THE ABDOMEN*

(An Interesting Case)

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Introduction

We would like to present a very interesting case of an abdominal swab travelling into the lumen of the intestine after it had been inadvertently left by the surgeon during a laparotomy. After a meticulous search of the literature one other parallel case could be found which was reported by Rakshit (1963). It is probable that other surgeons have come across similar cases but have not reported them. In both these cases (i.e. Rakshit's and ours) a swab was inadvertently left in the peritoneal cavity during an operation which did not deal with any portion of the gut, but the swab ultimately worked its way into the lumen of the small intestine in both the cases.

Rakshit (1963), reporting his case, found the swab inside the jejunum 3 years after the original operation. The patient was ultimately cured by a resection of the portion of the gut which contained the swab.

A foreign body left in the peritoneal cavity has sometimes been responsible for the production of acute or subacute intestinal obstruction. But the big swab inside the gut in both these cases did not produce obstruction though it might have been responsible for the malabsorption syndrome.

It is interesting to note the ultimate fate of the swab when it is accidentally left in the coelomic cavity. A detailed report of one case is given below where a large towel was discovered inside the small intestine 4-5 months after the original operation.

CASE REPORT

S. S., aged 24 years, a housewife from a middle class family, was admitted on 23-11-1967, with the following complaints:

Pain in the lower abdomen since her last operation (caesarean section) 4 months ago, especially during the act of defaecation. Occasional discharge of pus through a sinus situated along the scar since 4 months; difficulty in taking solid food since 3 months and occasional vomiting for 2 months.

Menstrual History

Menarche at 13 years; past cycles—regular; duration of flow 4-5 days. Has had no period since the last operation.

Present illness

The patient had a caesarean section in 1963 presumably for a contracted pelvis.

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Details of this operation were not available. Her post-operative course was uneventful. The child is alive and well. In 1967, she conceived again. She was staying in a small railway colony near Darbhanga. At 39 weeks, she suddenly experienced pain in the abdomen and fainted. She was transferred to the small railway hospital in the same colony where she was operated; a blood transfusion was given. She was told that the uterus had ruptured and the baby was stillborn. Her convalescence was stormy and she continued to have temperature. The wound had also not healed properly. She was subsequently transferred to Darbhanga Medical College, where she stayed for about a month. The wound healed but a discharging sinus persisted. A low grade temperature continued. As her general health did not improve, she came to Calcutta.

General examination

The patient was of average build and nutrition. B.P. 110/70 mm. of Hg., pulse —72/mm. Temperature normal. Heart and lungs were normal. Abdominal examination revealed an unhealthy abdominal scar with a discharging sinus. Midway between the umbilicus and the symphysis pubis there was a mass of 24 weeks' size, adherent to the abdominal scar.

Vaginal examination

Cervix was directed posteriorly. The size of the uterus could not be made out properly. The abdominal mass seemed to be the uterus of 24 weeks' size.

Provisional diagnosis

Subinvoluted uterus with utero-parietal fistula.

Investigations: Hb. 9 gm.%; W.B.C. 6400/cmm; poly-60%; lympho—24%; eosino —5%; M—2%; blood sugar—80 mgm./100 c.c. Urea—25 mgm./100 c.c.; X-Ray—chest and abdomen—N.A.D.

Hysterosalpingography: Showed the position of the utero-parietal fistula.

Laparotomy on 13-12-1967.

It was difficult to enter the peritoneal cavity because of dense adhesions of loops of intestine to the anterior abdominal wall. The sinus tract seemed to be connected with two loops of small intestine and the uterus. With difficulty the pelvis was approached and the uterus was inspected. The uterus, though united at the fundus, was gaping on the lower left side up to the left broad ligament. Here, the uterine cavity was opening into the peritoneal cavity. Several other loops of small intestine were adherent to the fundus of the uterus. One of the loops was very distended and contained a black mass which was considered to be scybala, the loop being misdiagnosed as the large intestine. This distended loop was not adherent to the uterus.

Total hysterectomy and left salpingo-oophorectomy was done. After this, the intestinal loops of gut were inspected and an attempt was made to separate the dense adhesions and to restore the normal anatomy. The loop that contained the scybalous mass was examined. It was found to be injured on its postero-lateral aspect from which black faeces were escaping out. The loop was now diagnosed to be an immensely distended part of the ileum. The black mass seemed solid, and on palpation it was found to be a part of a towel. The swab was slowly extracted and was found to be a standard size abdominal pack (46 cm. x 37 cm.), impregnated with black faeces. Considering the unique nature of the case and the dense adhesions between the loops of small and large intestines a general surgeon's help was sought and he completed the operation. He did resection and anastomosis of the small gut in two places and resection and anastomosis at one place in the large gut, in addition to a short circuit anastomosis in a loop of small intestine. There were small injuries to the gut which were repaired. Rubber drainage tubes were placed through the flanks and through the abdominal wound and the abdomen was closed in layers. These resections of the gut were necessary because of dense adhesions and consequent injury caused by separation of the adhesions.

Post-operative management was done by suction, fluid and electrolyte balance was maintained; blood transfusion was given. The patient kept well till the 4th day and ran a high temperature from 5th post-operative day. The abdomen remained soft; the urine drained normally. On the 6th

post-operative day, she was transferred to the surgical department. On the 8th day she developed a recto-vaginal fistula and on the 10th day she developed uraemia from which she died on the 13th post-operative day.

Discussion

The mortality and morbidity of an operation not only depend on the actual operation but also on the carelessness on the part of the surgeon and his assistants during the operation. Very often in a desperate case the surgeon has to close the abdomen quickly to save the life of the patient, and due to the extreme hurry an instrument or a towel may inadvertently be left in the peritoneal cavity.

The medical literature on forgotten foreign bodies (surgical instruments or surgical towels) in the abdominal cavity during a laparotomy is quite scanty. This is a subject of great medico-legal interest and many surgeons have been held responsible and made to pay heavy sums as compensation, when it was proved that they were negligent. Neville (1959) accidentally left a swab during an operation for ectopic gestation. At a subsequent operation for intestinal obstruction, the swab was found in the abdomen. Bierer (1955) left a swab (about 10″ long) during a caesarean section and this had to be removed by operation. Crossen and Crossen collected as many as 307 cases up to 1940 where abdominal swabs were found in the peritoneal cavity. But we could not find any published report where the swab was found inside the intestinal lumen except for the solitary case reported by Rakshit in 1963. He reported an interesting case where he found the swab inside the lumen of the jejunum. In the present case the swab was found inside the lumen of the ileum four to five months after the first operation for ruptured uterus. It is rather strange that an abdominal towel left in the peritoneal cavity could find its way into the lumen of the intestine. It is difficult to believe such things unless one encounters them personally. It is difficult to explain this occurrence and we surmise that this could happen in the following way.

Firstly, the foreign body excites a local aseptic irritation and inflammation with exudation of inflammatory fluid. It is then encapsulated by deposits of fibrin and adhesions to neighbouring viscera occur. Ultimately, a localised (intraperitoneal) abscess develops which bursts into the intestinal lumen and the swab thus finds its way into the lumen. The coils of intestine and the omentum gradually close upon this area and seal up the rent.

Foreign bodies inside the gastro-intestinal tract usually come out through the rectum. In this particular case the swab could not pass through the ileocaecal junction because of its size. It also did not produce acute intestinal obstruction, as liquid and gas percolated through the gauze. However, the patient was sufferring from what can be termed malabsorption syndrome.

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