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MULTIMEDIA ARTICLE - Clinical Imaging

A Bizarre Abdominal Cystic Lesion

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Summary

In spite of careful intraoperative precautions and gauze counts, mistakes can still occur during surgery. In the case reported, a retained gauze leaved during a surgical approach for removing a solid-cystic papillary tumor localized in the pancreatic tail, caused both persistent abdominal discomfort and the presence of an abdominal cystic lesion at imaging techniques. When a previous operative history is present, a foreign body should be taken into account in the differential diagnosis of a patient with an intra-abdominal cystic mass. Finally, radio-opaque marker should be routinely used by surgeons in order to reach a correct diagnosis in operated patients having retained gauze.

Case report

A 25-year-old woman was admitted to the hospital because of a three months persistence of abdominal discomfort localized in the upper left quadrant without any relationship with the food ingestion. The abdominal discomfort appeared immediately after an enucleoresection for a solid-cystic papillary tumor localized in the pancreatic tail; this tumor was found incidentally at an ultrasonographic examination carried out for dyspeptic symptoms. Surgery was carried out in a hospital outside Italy. She denied a history of alcohol consumption; she was no smoker and was no drug addict. On admission, the patient had painful at the deep palpation of the abdominal left upper quadrant without signs of peritoneal irritation. The arterial pressure was 115/70 mmHg and the cardiac rate was 72 beats per minute. Electrocardiography was normal and laboratory investigations were unremarkable. An abdominal computer tomography was performed (Image 1) and this examination showed a cystic lesion of 4.5x3.5 cm in size localized near the tail of the pancreas with a thick wall with poor contrast enhancement; the remaining pancreatic parenchyma was normal.

The pathological review of the surgical specimen of the previous hospitalization (Image 2) revealed that the margins of the tumor were not free of neoplasia and, according to our practice [1], the non-aggressive behavior of the tumor suggested us to perform radical resection of the pancreatic tail. Therefore, we decide to treat surgically also the cyst localized near the tail of the pancreas because the suspicion that the lesion was a pseudocyst due to a pancreatic fistula secondary to the

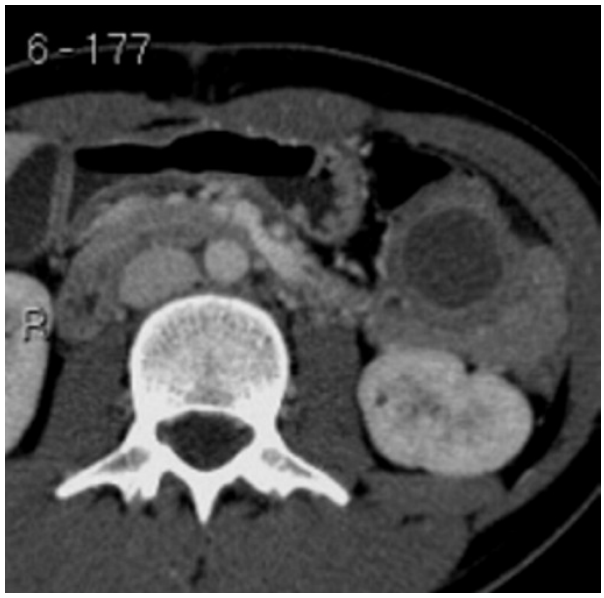

Image 1

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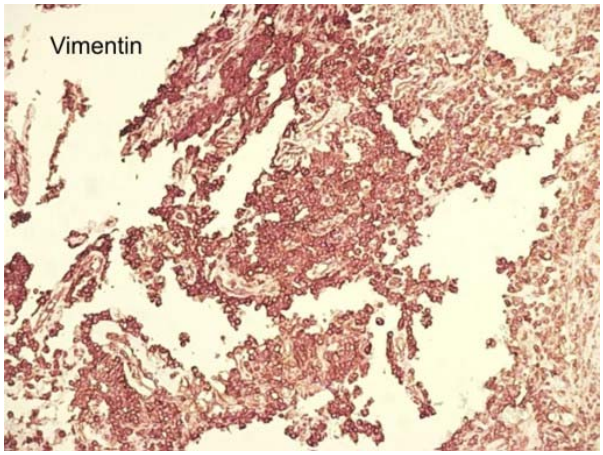

Image 2

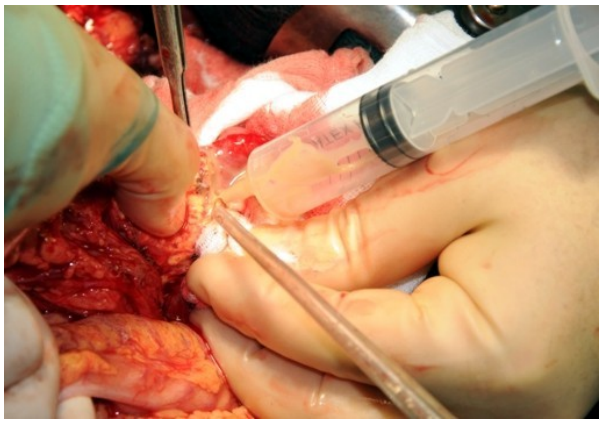

Image 3

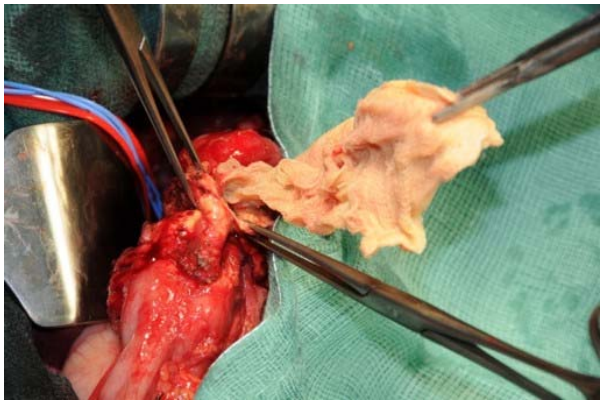

Image 4

enucleoresection of the tumor. At laparotomy the cyst was visualized: it was located out of the pancreas, between the transverse colon and the first loop of jejunum. Its aspiration showed that the content of the lesion was constituted of purulent material (Image 3). The cyst was then opened and a no radio-opaque surgical gauze leaved during the previous surgical approach was found (Image 4). The surgical procedure was completed by spleen preserving distal pancreatectomy. The postoperative course was uneventful and the patient is now in good clinical condition.

Conclusions

In spite of careful intraoperative precautions and gauze counts, mistakes can still occur during surgery. These errors seem most frequent in general surgery, followed by gynecology and obstetrics, and orthopedics [2]. In most instances, the retained foreign body induces an inflammatory reaction. The forgotten aseptic gauze can become a granuloma or even a pseudotumor without causing severe symptoms as in our patient [3].
In conclusion, when a previous operative history is present, a foreign body pseudotumor should be taken into account in the differential diagnosis of a patient with an intra-abdominal cystic mass. Finally, radio-opaque marker should be routinely used by surgeons in order to reach a correct diagnosis in operated patients having retained gauze.

Conflict of interest The authors declare that they have no conflicts of interest

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