

Clinical Image

Recurrence or Not Recurrence: This is the Question. Retained Surgical Item Mimicking an Inguinal Hernia

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CLINICAL IMAGE

Retained surgical items (RSI) are still an open issue with relevant medico-legal implications; the mere occurrence of these events is expression either of an objective omission by medical staff and carelessness of safety protocols, adducing to the involved health professionals a civil, administrative and penal accountability.

Since the surgical count of items in the operating room lacked, retained items were much more frequent; a retained surgical item (RSI) is classified as a "never events" but despite of this it still occurs with a rate of 0.1 to 0.3 per 1000 abdominal operations [1,2].

We present the case of a 70-years-old man who underwent to a surgical intervention of right inguinal hernia repair using an absorbable mesh in an Institution of Eastern Europe, in 2006.

In 2016 the patient came to the Emergency Department of our Hospital complaining of a sore palpable swelling at the groin, on the same side of the surgical intervention. The clinical exam revealed a non-mobile, tender mass of the right inguinal region which he had noticed for six previous months; the overlying skin was reddened and flushed.

The blood routine tests revealed a mild neutrophilic leukocytosis ($12.78 \times 10^3 / \mu\text{L}$) with raised level of inflammatory C-reactive protein (1.45 mg/dL) as a specific signs of flogosis: the patient was a febrile and his vital signs were normal.

Based on the suspect of cancer of the testicle with lymphatic diffusion the patient was referred to the urologist; the lesion wasn't compatible with a node and even radiological imaging as abdominal ultrasound, Computed Tomography (Figure 1) and Magnetic Resonance of the lower abdomen and pelvis (Figure 2) weren't diriment in detecting the nature of the lesion.

A surgical exploration of the site was mandatory so the patient was referred to the operating room.

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The inguinal exploration revealed a fibrous capsule which was tenaciously adhered to the mesh previously positioned; the mass was removed (Figure 3) and it proved to be a retained surgical sponge causing the inflammatory reaction (Figure 4). Non-absorbable mesh was inserted to reinforce the thinness of the underlying transversal is fascia.



Figure 1 CT scan, transverse section, the arrow indicates the right inguinal solid mass.

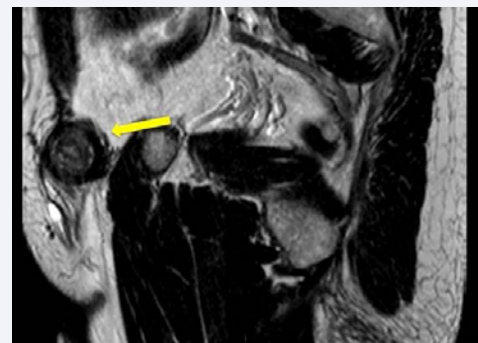


Figure 2 MRI of the abdomen showing a round image of the inguinal right region.



Figure 3 Chronic inflammatory response forming a capsule caused by a retained surgical item.



Figure 4 A surgical sponge is clearly visible.

The histological sample was represented by a fibrous, chronic inflammatory process surrounding the amorphous exogenous matter.

The patient had a regular clinical course; he was discharged on first post-operative day with a complete healing of symptoms within two weeks after the intervention.

After 10 months the patient was healthy and no signs of infection were observed.

According to the patient's medical history and literature rate of recurrence after hernioplasty which varies from 0.2% to 17% [3,4] an inguinal hernia recurrence was more likely to meet the clinical suspect but this case poses a differential diagnostic query for inguinal masses: lymphadenopathy, neoplasm of the spermatic cord, vascular abnormalities or sarcoma of soft tissues are conceivable but when all the options are excluded we should consider the possibility of iatrogenic means; based on this assumption, plain imaging are considered for any patient with unexplained symptoms after surgery to evaluate the presence of a RSI [5].

REFERENCES

1. Hyslop JW, Maull KI. Natural history of the retained surgical sponge. *South Med J.* 1982; 75: 657-660.
2. Patterson P. Preventing retained surgical items: what role doestechology play?. *OR Manager.* 2009; 25: 8-11.
3. Itani KM, Fitzgibbons R Jr, Awad SS, Duh QY, Ferzli GS. Management of recurrence of inguinal hernias. *J Am Coll Surg.* 2009; 5: 653-658.
4. Bisgaard T, Bay-Nielsen M, Kehlet H. Re-recurrence after operation for recurrent inguinal hernia. *Ann Surg.* 2008; 247: 707-711.
5. Stawicki SP, Cook CH, Anderson HL, Chowayou L, Cipolla J, Ahmed HM, et al. Natural history of retained surgical items supports the need for team training, early recognition, and prompt retrieval. *Am J Surg.* 2014; 208: 65-72.

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