

Case Report

Nephrocutaneous fistula due to textiloma with in the pelvicalyceal system

Soumya Mondal*, Amvrin Chatterjee, Souvik Chatterjee, Krishnendu Maiti, Dilip K. R. Pal*

Department of Urology, IPGME and R, Kolkata, West Bengal, India

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***Correspondence:**

Dr. Dilip K. R. Pal,

E-mail: urologyipgmer@gmail.com

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ABSTRACT

Textiloma or gossypiboma is an embarrassing surgical scenario. Nephrocutaneous fistula is itself a rare complication after renal surgeries, but due to textiloma, it is rarest of the rare. In this case, 30-year-old lady presented with the complaints of chronic seropurulent discharge from a wound on her right lumbar region. On exploration it was found to be a retained surgical sponge in pelvicalyceal system, which was there for last seven years.

Keywords: Gossypiboma, Nephrocutaneous fistula, Textiloma

INTRODUCTION

Nephrocutaneous fistula is a very rare complication after renal surgeries. The common causes for nephrocutaneous fistula formation are xanthogranulomatous pyelonephritis, tuberculosis, renal calculi especially impacted calyceal calculus and renal surgeries but nephrocutaneous fistula formation due to retained surgical sponge, that too within the pelvicalyceal system is very rare.¹⁻³ Gossypiboma or textiloma are the terms used to describe mass formation around retained foreign object in the body cavity, most commonly surgical sponge.⁴ Fistula formation is not uncommon in textiloma, but nephrocutaneous fistula due to textiloma is very rarely reported.⁵

CASE REPORT

A 30year old lady presented with the complaints of on & off seropurulent discharge from a wound on her right lumbar region. She had a history of right nephrolithotomy seven years back. After two months of the initial surgery, there was a small abscess formation on her right lumbar

region which spontaneously bursted out and became chronic wound with seropurulent discharge.



Figure 1: CECT KUB reported localized collection around the upper and midpole of rt kidney with complex cyst/mass in upper pole with no contrast enhancement.

She was previously treated with various antibiotics, but the discharge remained same. She was also had a history of excision of the sinus tract one year back, histopathology report was chronic inflammation, but the discharge again reappeared after two months. Renal function test reports were within normal limit. Urine culture and sensitivity report was sterile. Urinary AFB culture was also negative. CECT KUB reported localized collection around the upper and midpole of rt kidney with complex cyst/mass in upper pole with no contrast enhancement (Figure 1). Sinogram revealed fistulous connection extends within the pevicalyceal system (Figure 2). DTPA scan was done GFR of rt kidney was 35ml/min. After admission rt DJ stent was placed, as there was no decrease in the seropurulent discharge, open exploration was planned.

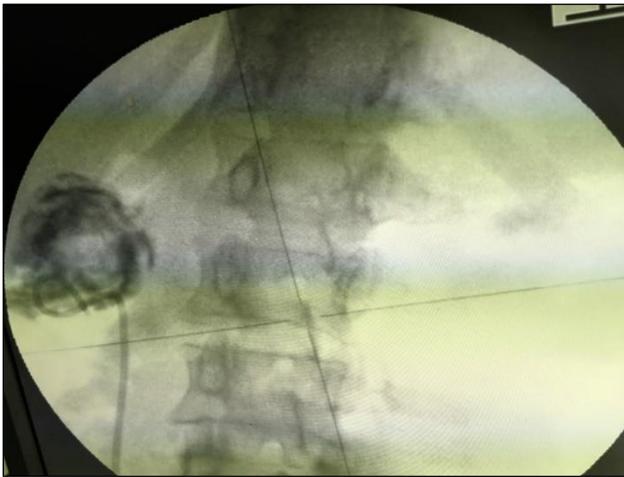


Figure 2: Sinogram revealed fistulous connection extends within the pevicalyceal system.

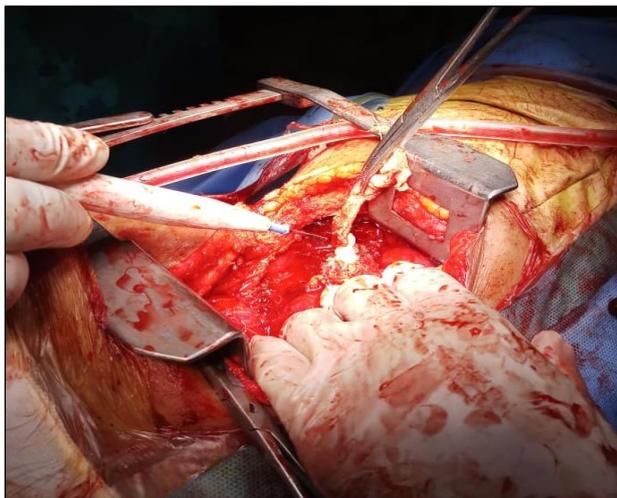


Figure 3: Intra operative picture showing retained surgical gauze in pelvicalyceal system.

Previous nephrolithotomy incision was used for exploration. Fistulous tract was found to extend up to a cyst like structure around the upper pole. On opening it

was found to be a localized walled off seropurulent collection and one wall of this cavity was densely adhered to the upper pole. On palpation of the upper pole, there was a suspicion that something is within the upper pole. Pelvicalyceal system was opened and surprisingly there was a retained surgical sponge, used seven years back during that nephrolithotomy operation (Figure 3).

DISCUSSION

Nephrocutaneous fistula is a rare clinical entity. Fistulous connection between kidney and surrounding organs is also uncommon, but nephrocutaneous fistula is the rarest. maximum fistulas follow the path of least resistance, that's why maximum nephrocutaneous fistulous opening was found in lumbar triangles. Fistula arising due to trauma or surgery not necessarily follow the path of least resistance.⁶ Gossypiboma or textiloma are the terms used to describe mass formation around retained foreign object in the body cavity. Textiloma is a notorious clinical complication that can lead to humiliating embarrassment and lawsuit also. The actual incidence of such cases could not be ascertained as maximum cases are not reported in the fear of medicolegal actions.⁷ The symptoms of retained sponge depends upon the size, site, and immune reactions (fibrinous or abscess forming). It may present with lump may or may not be associated with pain, fistula, intestinal obstruction, perforation or any kind of vague symptoms. Textiloma is commonly seen in cases of emergency surgery, heavy bleeding, improper sponge count, inexperienced staff, lengthy procedure and obesity.⁸ Radiological investigations are not very particular to diagnose textilomas unless the sponge has radiopaque marker. Nonspecific clinical finding associated with diverse radiological picture exacerbate the diagnostic dilemma.

CONCLUSION

Textiloma is a notorious and embarrassing clinical complication, but it can be avoided easily. Surgeons and scrub nurse should follow the basic recommendations proper preop and post op sponge count, proper communication throughout the procedure. It is better to use surgical sponges with radio opaque marker. Textiloma should always be kept in mind as a probable cause of fistula & soft tissue mass with a history of prior surgery.

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