CASE REPORT

RARE CASE OF TEXTILOMA OF NOSE PRESENTING WITH FAILURE OF EXTERNAL DCR AND NASAL OBSTRUCTION

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INTRODUCTION: It's not uncommon to have complications for a surgical procedure even after taking meticulous care about do's and don'ts. Retained foreign objects (RFO) are one of the underreported complications for obvious reasons of legal issues.[1,2,3,4] It can be either surgical instruments or surgical sponges or cotton balls. They are called as Gossypiboma, textiloma. The term "gossypiboma" is derived from the Latin gossypium ("cotton wool, cotton") and the suffix -oma, meaning a tumor or growth, and describes a mass within a patient's body comprising a cotton matrix surrounded by a foreign body granuloma. "Textiloma" is derived from textile (surgical sponges have historically been made of cloth), and is used in place of gossypiboma due to the increasing use of synthetic materials in place of cotton.

INCIDENCE AND CLINICAL PRESENTATION: A big chunk of textiloma cases are reported in abdominal, pelvic surgery, and neurosurgical cases. (Once in every 3000 to 5000 abdominal operations). The reason we possibly think would be a large space to be seen through a small opening where these materials can remain unseen. But in present era with use of endoscopes and better visualization textiloma in nose is very rare and only few cases have been reported. In rare instances it's found in paranasal sinuses possibly maxillary sinus being biggest and commonly opened will be the site. The exact statistical details of textiloma are not easy to determine as the case reporting is rare. And it might be cause for quite a lot number of revision surgery. And in many of them the radiological features may mimic recurrence of disease.

CASE REPORT: A 45 year old Muslim patient came with history of watering on right eye for past 5 months with nasal obstruction occasionally on right side. There was also history of purulent discharge in medial aspect of right eyes since 5 months. She also gives complaints of purulent nasal discharge which was continuous since then. There were no other complaints viz headache etc. she had watering of same eye 1 year back and she had undergone external DCR in some other hospital 6 months back. Following this surgery she was symptom free for only one month. On probing of lower canaliculus she had hard stop ruling out common canalicular duct obstruction and there was regurgitation of purulent and then followed with mucopurulent discharge from both the puncti. After this she was posted for diagnostic nasal endoscopy under local anesthesia which reveals a pinkish mass present in right lateral wall of nose near axilla of middle turbinate with purulent discharge smeared to its surface. It was painfull and soft on probing which left bleeding surface. There was no flow of fluid intranasally with lacrimal syringing. She was posted for revision endonasal DCR and excision biopsy of mass under local anesthesia.

Intra operatively the tissue was taken for biopsy and remaining mass was debrided with the help of powered microdebrider. There was sudden flow of purulent material from the remnant mass and fluffy ball was visualized in the lacrimal sac area which resembled a cotton ball. This sample was also sent for biopsy. Later usual steps were carried out to complete endonasal DCR.

Histopathology report showed refractile filaments in background of RBC and Granulation tissue suggesting "textiloma".

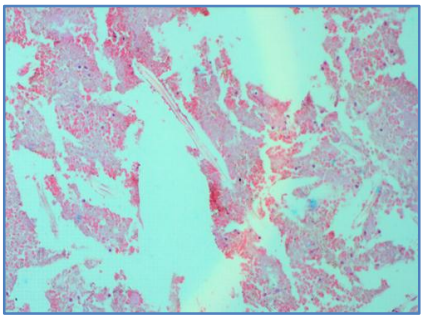

Fig. 1: 10x magnification of textiloma

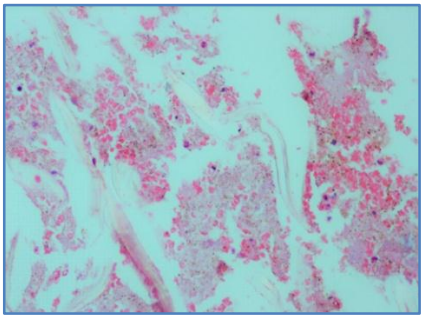

Fig. 2: 40x magnification of textiloma

DISCUSSION: Textiloma is not a very rare entity in abdomen and neurosurgical cases as there is huge potential space for surgeon and assistant to look after intra operatively. Even with strict instructions of swab counts and instrument count, in some situations like unplanned and hurried surgeries this complication is quite expected.

In external DCR there is very few possible mode of entry of a cotton ball into nasal cavity like control of anterior ethmoidal artery bleeding or bleeding from nasal mucosal edges or bleeding from injury to nasal septum or turbinates. In such rare act of commission it is better to be cautious about extra surgical step of inspection before closing the field.

This case of textiloma of nose presenting with failure of external DCR and nasal obstruction is first textiloma to be reported in literature as it is very rare.

CONCLUSION: In any surgical case inspection of surgical field before closing the field after the instrument and swab count should be mandatory with no excuses taken. And attending ophthalmologist should keep inspect nasal cavity before closing incision even though these swabs can easily be taken out with intransal route and included as a surgical step.

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