Groin textiloma after saphenectomy: resemblance to neoplasm

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Abstract

Background: Textilomas may mimic a malignant neoplasm and may occur in rare locations.
Clinical case: A 73-year-old female presented a groin tumor of 3 years duration after saphenectomy. Physical exam of the right groin area demonstrated an 8-cm oval tumor below the inguinal ligament and above the femoral vessels. An ultrasound and a CT scan showed a mixed cyst. During surgical exploration of the groin, an 8-cm tumor fixed to the femoral vein was extirpated en bloc. Histopathological results reported a textiloma. The patient had an uneventful postoperative evolution.
Conclusions: Textilomas may mimic a neoplasm, but their occurrence in the groin is exceptional.

Key words: saphenectomy, textiloma.

Introduction

Resection of the greater saphenous vein is no longer a frequent surgical procedure. Its complications are rare and could decrease even more through careful patient selection and application of a meticulous surgical technique.[1]

The unintentional persistence of textile materials in the surgical field, whether they be compresses or gauze, are called textilomas[2] and are a cause of significant morbidity and mortality.[3] They can also be confused with a malignant neoplasm.[4,5]

The presence of a textiloma in the groin is rare, and due to its rarity, we present a case report.

Clinical Case

We present the case of a 73-year-old female who was seen because of a tumor of 3 years evolution in the right groin. She stated that the mass appeared 1 month after undergoing bilateral saphenectomy. The lesion progressively increased in size and caused local intermittent pain. She denied any changes in her general health, hyporexia or loss of weight. On physical examination, in the right groin there was an oval, mobile 8-cm tumor below the inguinal ligament and above the femoral veins. Presumptive clinical diagnosis was adenomegaly vs. sarcoma vs. crural hernia. Imaging and laboratory studies (chest x-ray, liver ultrasound, blood test, and hepatic function tests) to rule out metastatic neoplasm were all normal. An inguinal ultrasound and CT showed a complex cystic tumor of 55 × 77 mm (Figures 1 and 2), and it was concluded that the problem was a probable neoplasm. For this reason wide resection of the tumor was scheduled. During surgery the tumor was excised with 1-cm margins of healthy tissue circumferentially in a tridimensional manner. Finally, the femoral vessels were reached and we proceeded to separate these from the artery, but they were intimately adhered to the vein. Vascular clamps were placed on the vessel in order to resect it with a fragment of its anterior wall, which finally was repaired with 6-0 nylon suture. Patient's postoperative evolution was satisfactory. The specimen was reported by pathology as a 7 × 5 × 4.5-cm cystic and uniloculated lesion with textile material mixed with fibrous tissue and scarce sallow fluid (Figure 3). The final diagnosis was fibroconnective tissue with fibrosis and acute and chronic granulomatous foreign body inflammation.

Discussion

In some series reporting on textilomas, females constituted ~60%.[3,6] Currently, due to advances in anestheisa, persons

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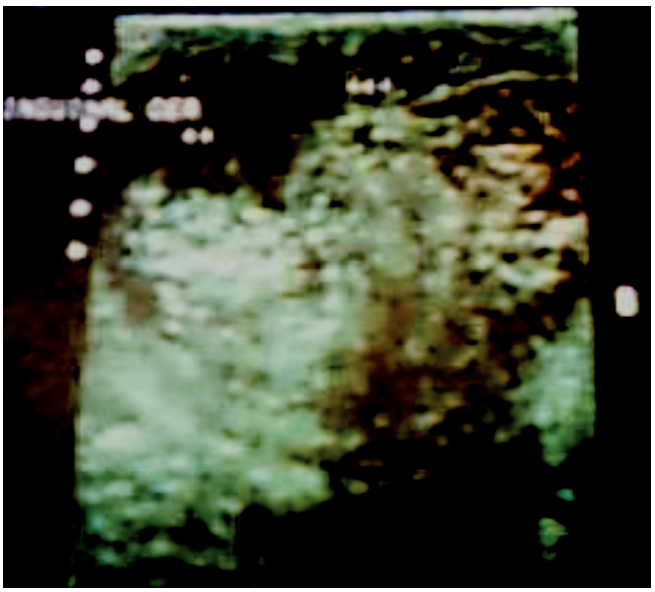

Figure 1. Gray-scale ultrasound. Cystic lesion is observed with heterogeneous content, which causes posterior reinforcement.

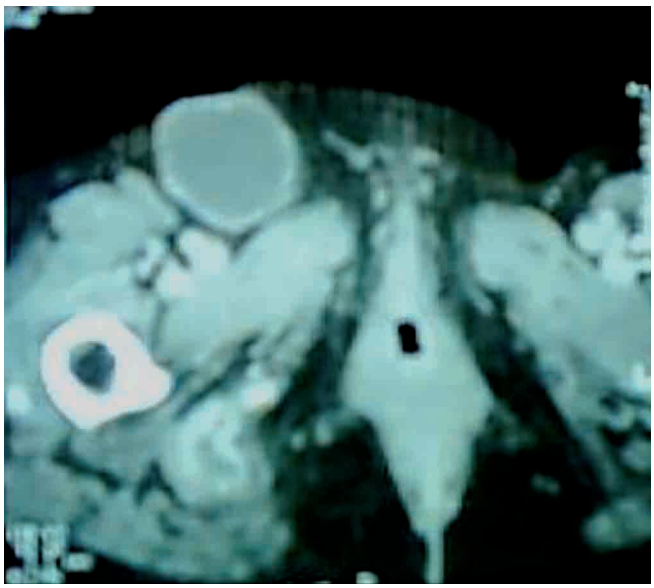

Figure 2. CT of the pelvis at the level of the groin. An oval tumor is noted with thick walls and heterogeneous content.

Figure 3. Macroscopic appearance of the resected tumor. It was opened to show the textile material in its central portion, and the pseudocapsule can easily be seen.

>64 years of age are able to undergo surgical procedures that previously they were not considered candidates for.[7]

Textilomas occur most frequently in the abdominal cavity, but they have been reported in other anatomic areas with the exception of the groin.[3,6,8] Also, textilomas have remained in patients for periods of 3 months to 38 years.[2,5-6,9]

In some reports it has been emphasized that conventional x-rays and ultrasound are adequate diagnostic methods for an abdominal textiloma.[3,10] However, other reports indicate that these techniques identify only 57.1% of cases.[8] CT may show great variability in the appearance and, consequently, may lead to mistaken diagnoses.[2,9]

Textilomas that manifest as a tumor occur in up to 24% of the cases in some series,[3] and they have been found in the abdomen,[10,11] spinal column,[9] liver[12] and retroperitoneum,[5] among other sites. Management is surgical resection and when confused with malignant neoplasms the procedure involves the organs that are apparently involved.[4-6,9-11] The outcome in the majority of these cases was satisfactory,[9,11-13] but a morbidity of 21.4-100% and a mortality of 14.2-25% have been reported.[3,8]

In conclusion, the best treatment for textilomas is their prevention. It is recommended to use radio-opaque textile materials and to carefully and diligently count the materials at the end of the surgical procedure. In cases subjected to emergency surgical procedures, x-rays should be taken before surgical closure .[6,8]

The following risk factors have been identified for these events: emergency surgery for trauma or profuse hemorrhage, unforeseen changes to a programmed surgery and patients with a high body mass index.[6,8,14]

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