Retained foreign bodies - A rare case of removal of surgical blade as retained foreign body from abdomen 5 years after surgery

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Abstract

Introduction: Foreign bodies forgotten or missed in abdomen include cotton sponges, artery forceps or other instruments, pieces of broken instruments or irrigation sets and rare tubes. Presence of retained surgical blade as foreign body is uncommon and significant patient safety challenge. Most common etiologies for presence of such foreign bodies are accidental, traumatic or iatrogenic. Most common surgically retained foreign body is the laparotomy sponge. We report the management of a case with a rare foreign body in the abdomen i.e. surgical blade and repair of congenital diaphragmatic hernia. A 38 years female reported to us with X-ray lumbo-sacral spine showing radio-opaque object in abdomen. We further investigated the patient and CT scan abdomen revealed–A metallic foreign body in the left hypochondrium just beneath the left lobe of liver; it was seen in close proximity to the transverse colon gut loops and left diaphragmatic eventration hernia–herniation of stomach, large bowel loop and omental fat into left hemithorax. Traditionally, diaphragmatic hernia was repaired by laparotomy and foreign body was removed after exact localization on C-arm.

Background: The genuine rate of RFBs is hard to decide, perhaps because of hesitance to report an event emerging from dread of legitimate repercussions and are most oftentimes found in the midsection. The event fluctuates between 1 of every 100 and 1 of every 5,000 for every single careful intercession and 1 out of 1,000-1,500 for all laparatomies. It has been evaluated that in excess of 1,500 instances of RFBs happen every year in the USA.[8,10] It has been assessed that one instance of a held thing post-medical procedure happens in any event once per year in any emergency clinic where 8,000-18,000 significant methodology are performed yearly. This gauge depends on claims information, however there likely have been uncounted cases settled outside the lawful framework. Mortality identified with RFBs is as high as 11% to 35%, accentuating the need to forestall this clinical intricacy. The significant reasons of RFBs are crisis mediations and spontaneous changes during the tasks. In addition, hefty patients with a higher weight file (BMI) and female patients because of troublesome gynecological methodology were accounted for to be the hazard bunches for this iatrogenic difficulty. RFBs is every now and again situated in the stomach and pelvic pits after gynecologic, thoracic, and upper stomach careful partitions, yet can likewise happen after orthopedic, urological, and neurological strategies

Method:- In the activity room (OR), a group of experts performs demanding errands under extensive time tension, which is profoundly unpredictable and inside powerful work. This workplace commands sturdy and foundationally applied procedures of care. These wellbeing rehearses must be sufficiently vigorous to ensure patients under the most clamorous of conditions yet be sufficiently basic to be applied and comprehended by all human services proficient, from the fledgling to the ace. Every single individual working in the OR has a typical moral, lawful, and moral duty to do whatever conceivable to give legitimate result. Gibbs et al. revealed that RFBs are because of helpless correspondence between the staff engaged with the OR. For example; specialist excusing reports of a miscalculation as mistaken, different intraoperative work force changes without exact cross-educational detailing, and blended messages between colleagues about the planning for the rising up out of sedation if intraoperative X-beam to recognize a missing thing is required. Berguer et al. looked at 235 cases and found that the vast majority of them were crisis surgery, spontaneous changes in the strategy performed and weight index.The Association of perioperative Registered Nurses Practice Committee presents point by point rules and best practices for evading held careful gadgets. As indicated by them exact checking (pattern and last) ought to be done and on the off chance that it is off base a radiograph will be gotten to guarantee that RFBs has not been inadvertently held. Additionally, a decent correspondence is fundamental previously and during the careful activity, at staff changes, at handoffs and progressing to the OR.

Results: RFBs are chiefly caused on account of different major surgeries being done at an equivalent time. RFB is possibly hazardous. It might cause genuine clinical and lawful issues between the patient and the specialist. In this manner, extraordinary consideration ought to be taken in the treatment of instruments during the surgeries is exceptionally fitting. Preparing of the specialist is essential to boost understanding security. Legitimate correspondence among the work force taking an interest in medical procedure planned for forestalling this clinical carelessness would help in relieving such blunders. At long last, more grounded laws against the capable specialist may help in giving equity to the patient.

Extended Abstract

Biography: Dr.Rajneesh Kumar M.S; FAIS; FLCS; FMAS; FIAGES; FICS. is an Associate Professor in the Punjab Institute of Medical Sciences [PIMS], India

This work is partly presented at 6th International Conference and Exhibition on Anesthesia and Surgery September 07-09, 2017 | London, UK