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Letters to the Editor

Gossypiboma after Le Fort I osteotomy that manifested as a lesion of the maxillary sinus

Sir,

Gossypiboma is a term that refers to an inflammatory reaction to a foreign body that is specifically composed of a cotton matrix left behind after a previous operation. Gossypiboma literally means "cotton" derived from Latin word gossypium and "a place of concealment" for Swahili word boma.[1] It belongs to a broad new category named retained surgical items. Diagnosis is made by the association of clinical and imaging examinations. Radiographic or computed tomographic (CT) features vary depending on the type of reaction produced by the body, or they may not be identified.[2]

A 56-year-old woman with a history of Le Fort advancement surgery 10 years previously reported with a complaint of right nasal congestion that had lasted for eight years. On examination, her right nostril was completely obstructed with a hypertrophied turbinate and deviated nasal septum. Routine CT with contrast showed that the septum was deviated to the right, with a 16×15 mm well-defined, hyperdense, lesion in the right middle meatus, and the possibility of an inverted papilloma (Fig.1). We planned to biopsy this through a Caldwell Luc approach under general anaesthesia, but on exploration, a gauze fibrin thread 5 cm long was pulled out of the sinus (Fig. 2). Postoperatively, all symptoms subsided and her breathing was much better.

The retention of a foreign body is considered a preventable event by the National Quality Forum.[3] Failure to adhere to guidelines in counting the swabs and surgical items in open operations is one of the risk factors, not exclusively for retained surgical items. To the best of our knowledge only five cases of gossypiboma in the oral region have been published.[4] A characteristic feature on CT is a peripheral ring of calcification around a reticular mass.[5] Radiopaque markers are now present on surgical sponges, and their appearances have been well documented. The gossypiboma, however, may still present a diagnostic problem if the marker is distorted by folding, twisting, or disintegration over a period of time. New technologies such as this and the "Electronic Computer-Assisted Sponge Counting System" aim to reduce the incidence of retained surgical items, with the reasoning that technological error is smaller than human error.

Fig. 1. Coronal slice from computed tomographic image showing a 16×15 mm hyperdense lesion of the right maxillary sinus.

Awareness among surgeons and radiologists can lead to early diagnosis and intervention, thus preventing further complications.

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Fig. 2. Intraoperative clinical photograph showing the piece of gauze that was retrieved from the right maxillary sinus.

Conclusion

To eliminate the risk of gossypibomas, all sponges should be counted at least twice, (once preoperatively and once post-operatively) the use of small sponges should be avoided, and only sponges with radiopaque markers should be used.

Ethics statement/confirmation of patient's permission

Ethics approval was not required as the patient's consent was obtained.

Conflict of interest

We have no conflicts of interest.

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Rapidly progressing myofibroma of the gingiva- a rare occurrence

Sir,

Myofibromas, (fibroblastic proliferative lesions that can progress and develop as soft tissue tumours) are rare benign neoplasms with a predilection for the head and neck region. They can affect the oral mucosa or the bones of the maxillo-facial region.

A 53-year-old woman presented with a 4week history of a rapidly growing lesion in the gingivae of the right lingual molar region. Clinically this was friable and resembled a pyogenic granuloma, measuring 2 cm in maximum dimension. The adjacent teeth were vital and no bone loss was evident on orthopantomogram. There was no ulceration or cervical lymphadenopathy. An incisional biopsy was suggestive of a myofibroma with excision being recommended for definitive diagnosis. However, in the 2-week wait before excision, the lesion enlarged rapidly to the extent of affecting her bite, and caused bleeding and pain (Fig. 1). Excision confirmed a myofibroma with an incomplete margin where it was attached to the lingual mandible (Fig. 2).

These rare entities are not well known in OMFS. Differential diagnosis includes pyogenic granuloma, fibrous epulis, peripheral giant cell lesions, and more aggressive lesions such as sarcoma and spindle cell tumours. Rapid progression can occur (as in this case) which can mimic malignancy.[1]

Intraorally myofibromas are commonly reported on the tongue followed by the buccal mucosa and gingivae. They are more common in males, with other 90% occurring before the age of 2 years.[2]

Fig. 1. Preoperative photograph showing the lesion.