

A 67-year-old woman was admitted to the emergency department with complaints of abdominal pain and distension for 20 days. She had not previously undergone surgery or suffered any accident. Abdominal ascites was detected. The ascites was exudative (leukocytes 2000/mm³, lactate dehydrogenase (LDH) 6060 U/L and glucose 0 mg/dL), and the patient was therefore transferred to our clinic. *Streptococcus pyogenes* grew in the ascites culture after a few days

During the laparoscopic examination, the visible peritoneal regions were covered with a 2-mm thick exudate and fresh fibrous bands were observed; a 6–7 cm by 1 mm yellow object was also detected at the upper part of the pelvic region and removed by means of biopsy forceps (Figures 1,2). The peritoneal biopsy sample was interpreted as fibrous peritonitis. The patient was discharged in a healthy condition after 1 week's treatment with ampicilline sulbactam combination therapy, and had no complaint at follow-ups 2 and 6 months later.

The foreign body was identified as plastic material by the forensic medicine department.

Of the foreign bodies that go into the gastrointestinal tract, 80–90% are excreted with no complication, 10–20% require endoscopic removal, and about 1% require surgical therapy [1,2]. The rate of foreign

body-related perforations has been reported to be 1% [2]. There are several reports of perforations caused by chicken-bones, fishbones, or toothpicks.

During a laparoscopic appendectomy, Neuman et al. [3] found a toothpick that perforated the cecum, but they were unable to find out how and when the toothpick had been swallowed. We were also unable to elucidate these questions in the case presented here. If the history provides no information that a foreign body was ingested or if the object is not radio-opaque, the specific reason for the complications usually cannot be identified. Here, we demonstrate the use of laparoscopy as a practical method that should be routinely used for the diagnosis and treatment of unidentified abdominal pain as well as in cases of ascites.

K. Tuncer¹, U. S. Akarca¹, E. Ö. Aktaş², T. İltir¹, A. Musoğlu¹

¹ Department of Gastroenterology, Ege University Medical School, Izmir, Turkey

² Department of Forensic Medicine, Ege University Medical School; Izmir, Turkey.

References

- ¹ Gongavare RD, Rose JS, Berdon WE et al. Intrasplenic foreign body. Am J Surg 1972; 124: 994–996
- ² Selivanov V, Sheldon GF, Cello JP. Management of foreign body ingestion. Ann Surg 1984; 199: 187–191

³ Neumann U, Fielitz J, Ehlert G. Perforation des Coecums durch einen Zahnstocher-seltene Differenzialdiagnose der akuten Appendicitis. Chirurg 2000; 71: 1405–1408

Corresponding Author

K. Tuncer, MD

Ege Üniversitesi Tıp Fakültesi
Gastroenteroloji Kliniği
35100 Bornova, Izmir
Turkey

Fax: +90-232-3745761

E-mail: drkoray@yahoo.com



Figure 1 A foreign body in the abdomen at the upper part of the pelvic region.



Figure 2 The removed foreign body.