PREOPERATIVE DIAGNOSES,1. Postoperative wound infection.,2. Left gluteal abscess.,3. Intraperitoneal pigtail catheter.,POSTOPERATIVE DIAGNOSES,1. Postoperative wound infection. There was an intraperitoneal foreign body.,2. Left gluteal abscess.,3. Intraperitoneal pigtail catheter.,PROCEDURES,1. Incision and drainage (I&D;) of gluteal abscess.,2. Removal of pigtail catheter.,3. Limited exploratory laparotomy with removal of foreign body and lysis of adhesions.,DESCRIPTION OF PROCEDURE: , After obtaining the informed consent, the patient was transferred to the operating room where a time-out process was followed. Under general endotracheal anesthesia, first of all the patient was positioned in the left lateral decubitus and the left gluteal area was prepped and draped in the usual fashion. The opening of the abscess was probed and there was a tract of about 20 cm going subcutaneously upward. I proceeded to enlarge the drainage area and to some degree unroofing the tract partially and then the area was débrided and then packed with iodoform gauze and a temporary dressing was applied.,Then, the patient was placed in a supine position, and I proceeded to remove the pigtail catheter after dividing it to undo its locking mechanism. It came out without any difficulty. Then, the colostomy was protected and draped apart, and the patient's abdomen was prepped and draped in the usual fashion. My initial idea was to just drain and debride the wound infection, which had a sinus tract at lower end of the midline incision. I initially probed the wound with a hemostat and this had at least 12 cm long tract and I

proceeded to excise the badly scarred skin that was on top of it and then continued the dissection to the fascia and I realized that the sinus tract was going through the fascia into the abdomen. Very carefully, I started dividing the fascia. Of course, there were several small bowel loops adhered to the area. The dissection was quite tedious for a while. Initially, I thought that may be there was an enterocutaneous fistula in the area, but then I realized that the tissue that was interpreted as an intestinal mucosa was actually a very smooth _____ tissue that was walling the sinus tract. I made a laparotomy of about 10 cm and I carefully dissected the bowel of the fascia. There was an area at the bottom which looked like a foreign body and initially I thought there was a mesh that can be used to close the abdomen, but later on this substance floated out by self and it was an elongated strip, maybe about 6 cm, which we sent to Pathology for examination. Initially, I have obtained a sample for culture and sensitivity for aerobic and anaerobic organisms.,I was very happy that we were not really dealing with enterocutaneous fistula. The area was irrigated generously with saline and then we closed the fascia with number of interrupted figure-of-eight sutures of heavy PPS. The subcutaneous tissue and the skin were left open and packed with Betadine-soaked sponges.,A dressing was applied. A small dressing was applied to the area where we removed the pigtail catheter and also we went down to the gluteal area and put a formal dressing in that area. The patient tolerated the procedure well. Estimated blood loss was minimal, and he was sent to the ICU and also

made acute care because of the need for a laparotomy, which we were not anticipating.