Dear Sir

Retained vaginal foreign bodies after childbirth is a perennial medico-legal problem and judgment has invariably been for the plaintiffs.\(^1\)\(^-\)\(^3\) The incidence of such foreign bodies like swabs and sanitary towels being left in the vagina after delivery was recently reported from Penang as 2.45,164 deliveries,\(^4\) at the University Hospital, Kuala Lumpur, from July 1982 to August 1984, 13 such cases were encountered or 1:980 deliveries, which is 22 times as frequent. Even this must be an underestimate as cases which may have been treated elsewhere were not included; small items like swabs and cotton wool could also have been discharged in menstrual or lochial flow without being recognised as such.

Diagnosis was usually delayed (Table I); only one (case 12) was detected before discharge from hospital, during resuture of episiotomy. This delay is not surprising as there were no specific symptoms, the most common of which was a malodorous vaginal discharge which the woman could confuse with lochia. Other symptoms included sensation of a vaginal mass in three women and fever in two. Two women had menstruated (cases 4 and 10), and one of them had already had sexual intercourse without realising anything amiss.

In four cases, episiotomy repair had been performed by a junior medical officer; one houseman was responsible for two cases while six different housemen were responsible for one each. It would appear that a lack of awareness of this problem and ignorance of procedures were contributory.

\[
\begin{array}{ccc}
\text{Case} & \text{Postnatal stay} & \text{Foreign body} & \text{Delivery-detection interval}^* \\
\text{(d)} & & & \\
1 & 2 & \text{tampon (x2)} & 7d \\
2 & 2 & \text{tampon} & 3d \\
3 & 2 & \text{gauze} & 27d \\
4 & 3 & \text{tampon} & 4\text{ mth} \\
5 & 1 & \text{tampon} & 12d \\
6 & 1 & \text{gauze} & 10d \\
7 & 3 & \text{gauze} & 4d \\
8 & 7 & \text{gauze} & 42d \\
9 & 4 & \text{tampon} & 22d \\
10 & 3 & \text{tampon} & 8wk \\
11 & 1 & \text{cotton wool} & 8wk \\
12 & 3 & \text{tampon} & 1d \\
13 & 1 & \text{tampon} & 6d \\
\end{array}
\]

\(^*\) d—day; wk—week; mth—months.

Inculcating the proper attitude and clinical approach in attending staff must therefore be considered the \textit{sine quo non} of prevention. Nevertheless, one lecturer was responsible for a case in which the patient had a caesarean section following failed forceps delivery (case 8). Banning the use of absorbent material during episiotomy suture\(^4\)\(^,\)\(^5\) is obviously impractical but small swabs or cotton wool should not be used as these are difficult to detect, especially when they are soaked with blood. In cases of doubt, vaginal examination though uncomfortable or even painful to the patient should be carried out. No other
preventable factors were found: the 12 vaginal deliveries were uncomplicated and there was only one woman with a third stage complication (haemorrhage).

REFERENCES


4 Lim E B. Ban on use of swab rolls after delivery. New Straits Times 1984; September 6: 3 (col 2).


Yours sincerely

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