Case report

STRANGULATED SPIGELIAN HERNIA

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SUMMARY
Spigelian hernia is a rare ventral hernia. Strangulation in Spigelian hernia is common but still seen very rarely in clinical practice. We report a case of strangulated Spigelian hernia in an elderly women which was managed satisfactorily and the patient discharged on ninth post operative day.

Key Words: Spegelian hernia, strangulation

INTRODUCTION
Spigelian is defined as a protrusion of preperitoneal fat, a sac of peritoneum, an organ, through a congenital defect or weakness in the Spigelian fascia1, 2. The hernial orifice of the Spigelian hernia is usually located along the semilunar line (Spigelian line) through the transversus abdominis aponeurosis (Spigelian fascia) close to the level of arcuate line3. It is usually located between the different muscle layers of the abdominal wall; therefore it is also called as interparietal, interstitial, intermuscular, intramuscular, or intramural hernia. We report a case of strangulated Spigelian hernia, which is intermuscular4.

CASE REPORT
A 70-year-old female was admitted through emergency in November 2003, with severe pain in the swelling present in the right iliac fossa for the past three days. It was also associated with absolute constipation and vomiting for two days. Previously the swelling was reducible for 2½ years and was not giving her any problems apart from mild discomfort. Past medical history included Hypertension, Diabetes Mellitus and two episodes of Myocardial Infarction during the past ten years but didn’t know the exact details as regards the timing. On examination she was vitally stable. Her diabetes was well controlled. Local examination revealed a lump in the right iliac fossa of approximately 7 x 7 cm, which was tense, extremely tender and without any cough impulse.

X-Ray abdomen (Fig. 1) showed multiple fluid levels confirming the signs of bowel obstruction. History clinical examination together with the X-Ray finding of small bowel obstruction confirmed the diagnosis of strangulated Spigelian hernia. A laprotomy was performed and a gangrenous segment of ileum measuring 16 cm was resected. The defect in the transversus abdominis aponeurosis and the internal oblique muscle was repaired with prolene. The patient recovered satisfactorily and was discharged on 9th post-operative day.

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* Received for publication: January 27, 2004
Revision accepted: June 25, 2004
DISCUSSION

A Spigelian hernia is an acquired ventral hernia through the linea semilunaris, the line where the sheaths of the lateral abdominal muscles fuse to form the lateral rectus sheath. Spigelian hernias are nearly always found above the level of the inferior epigastric vessels, and most often occur where the semicircular line - fold of Douglas - cross the linea semilunaris. Commonly, the patient is over the age of 50 years. Men and women are equally affected.

Clinical examination is the mainstay of the diagnosis. Ultrasound Scan for detection of spigelian hernia at the early stage has been found to be extremely useful. The diagnosis of spigelian hernia presents greater difficulties than its treatment. The clinical presentation varies, depending on the contents of the hernial sac the degree and type of herniation. The pain, which is the most common symptom, varies and there is no typical pain of spigelian hernia.

A Spigelian hernia may be confused with a lipoma or a parietal abscess, both were excluded in our patient on the basis of reducible swellings. Intestinal obstruction with or without is not a rare presentation. On the right side it can mimic acutely inflamed appendicitis. Spigelian hernias are rarely known to contain an acutely inflamed appendix, Crohn’s appendicitis, even an incarcerated Meckel’s diverticulum. Findings to facilitate diagnosis are palpable hernia and a palpable hernial orifice. Easily palpable spigelian hernias are not a diagnostic problem.

The treatment of spigelian hernia is surgical, and the risk of recurrence is small. A gridiron incision is excellent for operations for palpable hernias. If the hernia cannot be palpated preoperatively, preperitoneal dissection through a vertical incision is recommended. This gives good exposure, facilitates hernioplasty, and permits preperitoneal exploration and treatment of other abdominal wall hernias. The incision is also suitable for exploratory laprotomy, which should be performed on patients with abnormal ultrasonographic or computed tomographic findings in whom no palpable hernia can be detected preoperatively. A laprotomy was performed in our case because of the signs of the strangulation of spigelian hernia and intestinal obstruction.

REFERENCES