

A JINXED VISITOR IN AN IRREDUCIBLE EPIGASTRIC HERNIA- A RARE CASE REPORT

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ABSTRACT

Acute gastric outlet obstruction is a rare entity causing a nightmare to the treating surgeon and the patient. Etiologies include foreign body ingestion, opposing peptic ulcers, gastric volvulus, hiatus hernia. Causes for gastric outlet obstruction presenting with epigastric mass are epigastric hernia containing stomach pylorus, trichobezoar and carcinoma stomach. After an exhaustive literature review, only 6 cases of epigastric hernia with stomach as content could be found.

KEYWORDS : Epigastric hernia, Stomach, Gastric Outlet Obstruction.

INTRODUCTION & BACKGROUND:

A hernia is a protrusion of a viscus or part of a viscus through an abnormal opening into an abnormal situation with its coverings[1]. Epigastric hernia is a rare form of ventral hernia and occurs through the linea alba anywhere between the xiphoid process and the umbilicus[2]. It accounts for 0.4–1.5% of all abdominal wall hernias as clinical presentation and approximately 5% general population at autopsy[3,4].

Often, these defects are less than 1 cm in diameter and contain only extraperitoneal fat which produces a mushroom shaped subcutaneous swelling[5], hence it is called sacless hernia and a voluminous epigastric hernia with sac is a rare entity and we present one such rare case presented with epigastric swelling containing stomach as content with gastric outlet obstruction.

CASE REPORT:

A 62-year-old female presented with a sudden onset, painful and irreducible epigastric swelling for past 2 days which was associated with colicky pain, vomiting which contains partially digested food particles and obstipation for past 2 days. Patient had tachycardia and signs of some dehydration. On examination, an epigastric swelling (12x10cm), which was hemispherical, lower margin was 2cm above umbilicus, firm, tender, no palpable cough impulse and irreducible. On attempting Ryles tube, resistance was felt towards the end of passing tube and the content was non-bilious, partially digested food particles. Per-rectal examination showed no faecal staining.

CECT of Abdomen revealed a defect (3.2x6.2 cm) in epigastric region with herniation of antropyloric region of stomach and omentum with diffuse omental fat stranding suggestive of irreducible epigastric hernia.

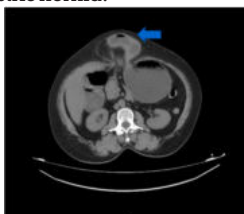


Figure1: CECT Abdomen showing epigastric hernia with antropyloric herniation through the defect[Blue arrow mark]

After optimization, patient underwent emergency laparotomy where sac was opened, and content was found to be viable distal body and pylorus of stomach with omentum which was congested. Contents were reduced , excess sac removed, rectus closed and meshplasty done. Post-operative course of events was unremarkable.



Figure 2: Delineated epigastric hernial sac



Figure 3: Sac opened and content was stomach- distal body and pylorus



Figure 4: Contents reduced, Sac excised and rectus closed



Figure 5: Onlay meshplasty done

DISCUSSION:

Pain associated with irreducible epigastric hernias is often due to vascular compromise of the herniated preperitoneal fat but it may mimic a peptic ulcer and hence a thorough gastrointestinal examination is done before the symptoms can be ascribed to the hernia. Often it is irreducible/incarcerated due to a narrow neck and hence, a cough impulse may not be demonstrable.

There have been reports of various rare intraabdominal pathologies being manifested as an epigastric hernia including bile duct cyst and gall bladder cancer [6], pseudomyxoma peritonei [7], floating gall bladder with acalculous cholecystitis [8] and interparietal omentocoele [9]. Although epigastric hernia are usually small and contain preperitoneal fat, rarely they may be voluminous containing viscera. There have been cases reported of strangulated epigastric hernias containing small bowel [10,11,12,13], requiring resection and anastomosis, or round ligament of liver [12]. However, after an exhaustive literature search, only six cases of incarceration of stomach in an epigastric hernia could be found [14,15,16], the earliest dating back to 1934 [17,12], causing gastric outlet obstruction [18].

In this case report, patient had large irreducible epigastric hernia with stomach body and pylorus [causing gastric outlet obstruction] with omentum as content which was viable, hence the contents reduced and defect closed with onlay meshplasty.

CONCLUSION:

All gastric outlet obstructions need not always be due to a luminal pathology. Diagnosing the acute gastric outlet obstruction cause preoperatively can be advantageous in providing correct line of surgical management. A true epigastric hernia with a peritoneal sac and bowel contents is a rarity. Therefore, a high index of suspicion for strangulation should be kept in mind in case of big epigastric hernia with acute abdominal pain and recent-onset irreducibility.

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