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Clinical Research

RICHTERS HERNIA A DECEPTIVE ENTITY : OUR EXPERIENCE OF SIX CASES.

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ABSTRACT Richter's hernia is a deceptive clinical entity because strangulation may start early and often there is absence of obstructive symptoms. The diagnosis may be difficult due to innocuous initial symptoms and sparse clinical findings. Absence of cough impulse and overlying skin erythema in a swelling at proposed hernia site should heighten the suspicion of Richter's hernia. Radiological imaging by contrast enhanced C T scan is helpful in making early exact diagnosis. Manual reduction (taxis) should be avoided as it may lead to perforation due to inadvertent reduction of gangrenous bowel. Once the diagnosis is made urgent operation must be carried out.

KEYWORDS : Richter's Hernia;enterocele

Introduction :

Richter's hernia is defined as the protrusion of the anti mesenteric wall of a bowel loop through a rigid orifice in the abdominal wall. Most often these hernias are diagnosed in sixth and seventh decades of life and comprise 10 percent of strangulated hernias[1]. The common sites of occurrence are the femoral ring, deep inguinal ring, and at incision site, at trocar sites after laparoscopic procedures(10 mm or larger ports)[2] Most surgeons now routinely close the fascia of these sites to prevent the herniation.

These types of hernias may often have delayed diagnosis or even misdiagnosis as intestinal obstruction is often absent since the lumen of the gut usually remains open. Hence leading to greater preoperative delay, rate of bowel resection, length of hospital stay, and postoperative morbidity and mortality rates. Due to its possible complications an accurate preoperative diagnosis and timely surgical management are mandatory.

We present our experience of treating six cases of Richter's hernia at different sites.

Material and methods :

Six cases of emergency surgery at JNU medical college hospital, Jaipur were found to have Richter's hernia during last two and half years. Details are as under :-

S no	Patient (Sex)	Age (yrs)	Presentation	Operative findings	Remark
1	Male	40	Peritonitis	Ileal loop(1feet from ICJ) have two perforations at anti-mesenteric border	H/O reduction of right inguinal swelling
2	Female	70	S A I O	Left obturator richter hernia	CECT diagnosed preoperatively
3	Female	60	Right inguinal swelling	Right femoral richter hernia	Swelling partially compressible, no cough impulse
4	Female	50	Obstructed hernia	Right inguinal richter hernia	-
5	Male	43	Obstructed hernia	Right inguinal richter hernia	-
6	Male	28	Acute intestinal obstruction	Left inguinal richter hernia	Left inguinal swelling missed

SAIO : Sub acute intestinal obstruction

Discussion :

Richter's hernia is defined as an abdominal hernia in which only part of the circumference of the bowel is entrapped in the hernial sac[3]. It is a deceptive entity because strangulation may start early and often there is absence of obstructive symptom[3]. Normally, patients with Richter's hernia are 60 to 80 years old[1].

The high mortality which is found in this has mainly resulted from misdiagnosis, delayed diagnosis and/or delayed operation.

The diagnosis of Richter's hernia may be difficult because of the apparently innocuous initial symptoms and sparse clinical findings. The diagnosis may remain presumptive until clearly confirmed at surgery. The first mild symptoms such as vague abdominal pain and slight malaise may not be appreciated resulting in delayed diagnosis. The most constant physical finding in a swelling over a potential hernia orifice is tenderness[3] and overlying skin erythema. Further absence of cough impulse on a swelling at proposed hernia site should also be suspicious, as was noted in our case no3(table).

Radiological imaging by Ultrasonography and Computed Tomography can facilitate or confirm the clinical diagnosis[4], is an excellent tool . Abdominal x-ray may be helpful in showing features of ileus like dilated bowel loops and air fluid levels. In our case no2 exact diagnosis of obturator richter hernia was established preoperatively by contrast enhanced C T scan.

Once the diagnosis is made, urgent operation must be carried out as if surgery is delayed, perforation into other compartment such as vulva, thighs or peritoneal cavity may happen and has shown severe morbidity and mortality[3]. It should be remembered that manual reduction should be avoided as it may lead to perforation due to inadvertent reduction of gangrenous bowel. In our first case laparotomy performed for peritonitis revealed two perforations on ileal loop at anti-mesenteric border, it was due to manual reduction of gangrenous bowel loop.

Strangulated Richter's hernia demands emergency surgery. The main goal in these patients should be to reduce the systemic toxin load from the gangrenous herniated tissue[3]. If the typical coin lesion of a bowel wall is nonviable but not yet perforated, has not affected more than 50% of the circumference and not extended to the mesenteric border than it can be under sewn. If nonviable bowel wall is more than the 50% of the circumference and if it extends into the mesenteric border then resection of the gangrenous segment and anastomoses is required[1]. Repair of the hernia orifice should never be omitted if recurrence of Richter's hernia is to be avoided[5].

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