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A CASE REPORT- PERINEAL HERNIA

Surgery

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ABSTRACT

Pelvic floor hernia is an extremely rare hernia. Perineal hernia is the result of failure to seal the perineal or extraperitoneal contents that go through the pelvic diaphragm. Primary perineal hernia may occur anterior or posterior to the superficial transverse perineal muscle, occur most commonly in the age group of 40-60years and are more common in women(usually older multiparous) than in men. Perineal hernias are generally repaired through a transabdominal approach or combined transabdominal and perineal approaches. A 37 years old Multigravida female presented to us with complains of pudendal discomfort and swelling since 3years.USG suggestive of 8mm break (HERNIA) containing bowel loops in right inguinal region.

Although the hernia content could not be identified preoperatively, the swelling was diagnosed as a perineal hernia, and open approach was performed. Postoperative period was uneventful and discharged on POD2 and no signs of recurrence has been noted for 6 months postoperatively.

KEYWORDS

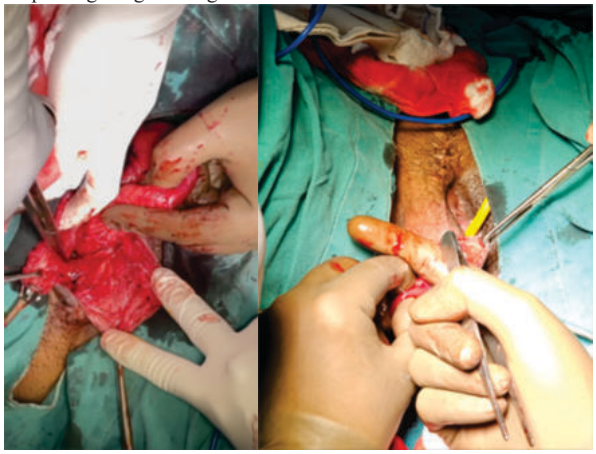
Perineal hernia, open approach, laparoscopic repair

INTRODUCTION

Pelvic floor hernia is extremely rare hernia. Perineal hernia is the result of failure to seal the perineal or extraperitoneal contents that go through the pelvic diaphragm. Primary perineal hernia may occur anterior or posterior to the superficial transverse perineal muscle , occur most commonly in the age group of 40-60years and are more common in women(usually older multiparous) than in men. Symptoms are usually related to protrusion of a mass through the defect that is worsened by sitting or standing . Perineal hernias are generally repaired through a transabdominal approach or combined transabdominal and perineal approaches.

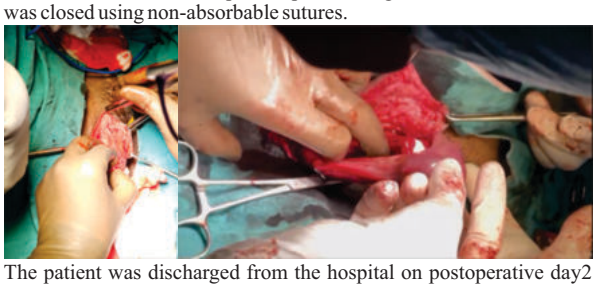
CASE PRESENTATION

A 37 years old Multigravida female presented to us with complains of pudendal discomfort and swelling for 3years, increased on standing and relieved on lying down, associated with pain for 7 days.On presentation, a lemon sized mass was seen in the right labium major on standing and was irrreducible on lying down. There was no tenderness. Her surgical history included hernioplasty on the right side (documentation unavailable) and 2 LSCS at an interval of 2 years. On examination in standing position ,a swelling of the right labium major was felt ,impulse on coughing was not very much appreciated. Standing USG suggestive of 8mm break (HERNIA) containing bowel loops in right inguinal region.



Although the hernia content could not be identified, the swelling was diagnosed as a perineal hernia, and open approach was performed.The patient was placed in a jack knife position throughout the surgery. Hernial sac was identified ,reduced and repaired.

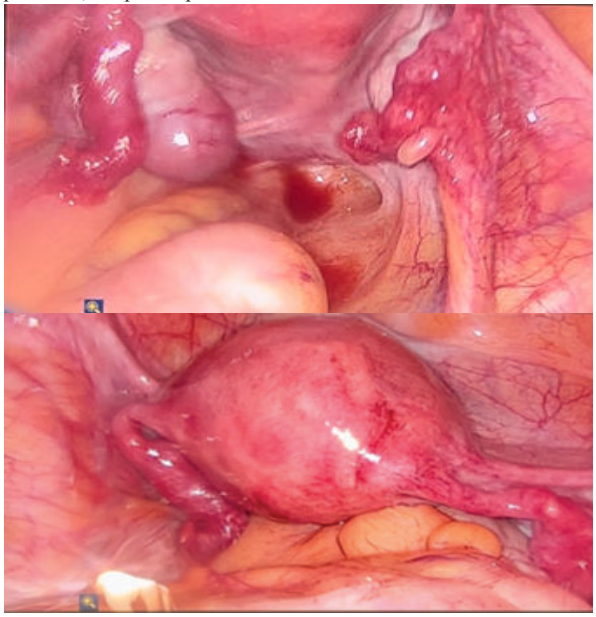
The excised Sac was sent for biopsy. Diagnostic laparoscopy was performed, a 2cm hernial orifice was found in the pouch of Douglas and the lumen extended upto the perineal region. The hernial orifice was closed using non-absorbable sutures.

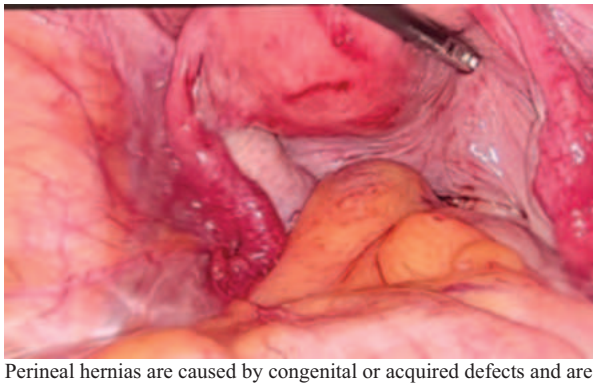


The patient was discharged from the hospital on postoperative day2 and followed for 6months, showed satisfying surgical results with no sign of recurrence. Biopsy report was followed up ,suggested of hernial sac with features of strangulated hernia.

DISCUSSION

Perineal hernia is an extremely rare condition. Garangeot was the first to publish a case of primary perineal hernia in 1743 as reported by Stamatiou et al.Thomas first classified vaginal hernias into five groups in 1885. Later, in 1940, Wilensky and Kaufman classified pelvic floor hernias as extravaginal, peritoneal vaginal, perineal, hydrocele, pudendal, and pelvic quasi hernias.





Perineal hernias are caused by congenital or acquired defects and are uncommon. These hernias may also occur after abdominoperi- neal resection or perineal prostatectomy.

A primary perineal hernia may occur anterior or posterior to the superficial transverse perineal muscle.An anterior perineal hernia passes through the pelvic diaphragm, and enters the deep perineal space. It then penetrates the perineal membrane and is found in the superficial perineal space. The sac of the hernia is then covered by the membranous layer of the superficial fascia; then, more superficially, it follows the fatty layer of the superficial fascia and the skin. The hernia presents as a mass in the labium majus. This kind of perineal hernia is found only in females.

Posterior perineal hernias that pass between the pubococcygeus and ilioeoccygeus muscles are called upper posterior perineal hernias. Those passing between the iliococcygeus and coccygeus muscles are named lower posterior perineal hernias. After passing through the pelvic floor, a posterior perineal hernia enters the ischioanal fossa and presents as a lump below the lower margin of the gluteus maximus muscle or as a swelling between the anus and the ischial tuberosity.

In this case, the patient presented with bulging of the labium major and was diagnosed with primary anterior perineal hernia.

Perineal hernia can be diagnosed clinically using sonography, CT, MRI, and herniography. It may be mistaken for lipoma, fibroma, Bartholin cyst, rectocele, cystocele, or rectal prolapse.

Perineal hernias are generally repaired through a transabdomi-nal approach or combined transabdominal and perineal approaches. After the sac contents are reduced, small defects may be closed with nonabsorbable suture, whereas large defects are repaired with prosthetic mesh.

Sorelli et al recently reported THE advantages of the laparoscopic approach in perineal hernia repair.[7] Ghellai et al and Franklin et al reported a laparoscopic approach using such mesh for pelvic defect closure.Cali et al reported a recurrence-free case using nonabsorbable mesh repair for a large pelvic floor defect.[1]Simple approximation of the defect may be feasible in some cases, but in long-standing cases, the pelvic floor is deficient and requires autologous or prosthetic materials.

We opted for perineal approach in this case, sac was excised after identifying and reducing the contents. Defect was closed with non absorbable suture. Postoperative period was uneventful and discharged on POD2 and followed for 6 months with no recurrence.

TABLE 1 Reported perineal hernia (n = 29)

	Author	Reported year	Age (y)	Gender	Congenital or acquired	Position	Symptom	Hernia content	Surgical approach	Procedure
Case 1	Kondo	1936	26	Female	Ac	P	Bulging	Bowel	Abdominal	Suture
Case 2	Hirata	1947	40	Female	Ac	P	Bulging	Bowel	None	Conservative
Case 3	Amos	1951	40	Female	Ac	P	Bulging	Small bowel	Abdominal	Suture
Case 4	Richard and Ruben	1968	53	Male	Ac	P	Bulging	Sigmoid colon	Abdominal	Suture
Case 5	Thomford and Sherman	1969	66	Male	Ac	P	Rectal pain	Small bowel	None	Conservative
Case 6	Coussement et al	1978	0 (day 0)	Female	C	P	Bulging	Rectum	N/A	N/A
Case 7	Coussement et al	1978	0 (day 2)	N/A	C	P	Bulging	N/A	N/A	N/A
Case 8	Sato et al	1979	44	Female	Ac	A	Bulging + pain	N/A	Abdominal	Suture (recurrence)
Case 9	Vincent et al	1984	70	Female	Ac	P	Painful mass	Rectum	Abdominal	Suture + muscle flap
Case 10	Hubbard and Egelhoff	1989	0 (day 1)	Female	C	P	Bulging	Colon	N/A	N/A
Case 11	Edward et al	1990	68	Male	Ac	P	Bulging	Sigmoid colon + small bowel	N/A	N/A
Case 12	Rebecca et al	1992	64	Female	Ac	P	Constipation	Sigmoid colon	Abdominal	Mesh
Case 13	Ito et al	1994	67	Female	Ac	P	Bulging	N/A	Abdominal	Suture + broad ligament of uterus patch
Case 14	Padilla et al	1999	35	Female	Ac	A	Bulging	N/A	Perineal	Mesh
Case 15	Yagi et al	2000	47	Female	Ac	A	Bulging	N/A	Laparoscopy	Mesh
Case 16	Kuroki	2001	72	Female	Ac	A	Bulging	N/A	Abdominal	Suture + mesh
Case 17	Amano	2002	68	Female	Ac	P	Discomfort	Sigmoid colon	Abdominal	Suture
Case 18	Mara et al	2005	68	Female	Ac	P	Discomfort	Sigmoid colon	Abdominoperineal	Mesh
Case 19	Preiss et al	2006	75	Female	Ac	P	Back pain	Small bowel + omentum	Abdominal	Suture
Case 20	Dirk et al	2006	67	Female	Ac	P	Protrusion	Small bowel	Abdominal	Suture + mesh
Case 21	Jessica et al	2009	57	Female	Ac	P	Fullness+ pain	Small bowel	Laparoscopy	Suture
Case 22	Washiro et al	2010	81	Female	Ac	P	Discomfort	Small bowel	Abdominal	Uterus patch
Case 23	Sorelli et al	2011	45	Female	Ac	A	Discomfort	N/A	Laparoscopy	Mesh
Case 24	Dragan et al	2012	0 (day 0)	Female	C	P	Bulging	Rectum	Perineal	Suture
Case 25	Raghunath and Rajgopal	2013	42	Female	Ac	P	Bulging	Small bowel + colon + urinary bladder	Abdominoperineal	Suture + mesh
Case 26	Kurumboor and Palanisami	2013	63	Female	Ac	P	Bulging	Urinary bladder	Laparoscopy	Mesh
Case 27	Jorge and Juan	2017	71	Male	Ac	P	Bulging	Sigmoid colon + rectum	Abdominal	Mesh
Case 28	Mistry et al	2018	87	Female	Ac	P	None (incidental)	Small bowel + omentum	N/A	N/A

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