



A RARE CASE OF LUMBAR HERNIA WITH CECAL PERFORATION -A DIAGNOSTIC SURPRISE

General Surgery

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ABSTRACT

The clinical presentation of lumbar hernia as acute abdomen due to cecal perforation is very rare. Most common presentations of lumbar hernia are low backache, weakness or numbness in one leg or foot. But in this scenario patient presented with acute abdomen. This study aims to present a detailed case report on the infrequent occurrence of lumbar hernia with cecal perforation. In lumbar hernia with descending colon as content which causes Intestinal obstruction with proximal bowel dilatation further complicated by cecal perforation. The objectives are to describe the clinical presentation, diagnostic challenges, surgical intervention, postoperative management, and to review relevant literature to highlight the complexity and rarity of this case.

KEYWORDS

INTRODUCTION

Lumbar herniation occurs in the region of the flank bounded by the 12th rib, the iliac crest and the erector spinae and external oblique muscle groups.¹ Herniation in this area is uncommon with fewer than 300 cases described in the literature. Obstruction with cecal perforation is rare.² We describe such a case presenting as distal large bowel obstruction with cecal perforation.

CASE REPORT

A 66-year-old female came to emergency with c/o distention for the past 4 days. The patient has not passed flatus or stools for the 4 days. C/o abdominal pain and vomiting for 6 hours. No h/o fever/ trauma /decreased urine output / jaundice / melena / haematochezia / breathlessness. The patient has no surgical history.

EXAMINATION REVEALED

- PR 128bpm, RR 28cyc/min.
- The patient looked toxic and not comfortable at rest.
- Generalised distension of abdomen with umbilicus flushed to surface.
- Tenderness -diffuse all over abdomen
- Guarding +
- On percussion- Liver dullness was obliterated.

Figure 1 X-ray of abdomen erect and supine revealed hollow viscus perforation



Figure 1 An X-ray revealed air under the right hemidiaphragm.

Figure 2.. ACT scan revealed pneumoperitoneum due to hollow viscus perforation and lumbar hernia defect size 5*3 cm with descending colon as content. Hence, the patient was shifted for emergency laparotomy.



Figure 2 INTRA OPERATIVE FINDINGS

A turbid colour aspirate of 500 mL was drained. Defect size of 5*3 cm present approximately at the level of superior lumbar triangle, with descending colon as content. With meticulous dissection colon released and appears to be healthy and viable with adequate vascularity. Defect was closed with prolene. Whole bowel wash done. 0.5*0.5 cm ulceration present over anterior cecum, primary closure done. The colon proximal to herniated part dilated. Distal to that part collapsed. After thorough wash, DT kept. Abdomen closed in layers.

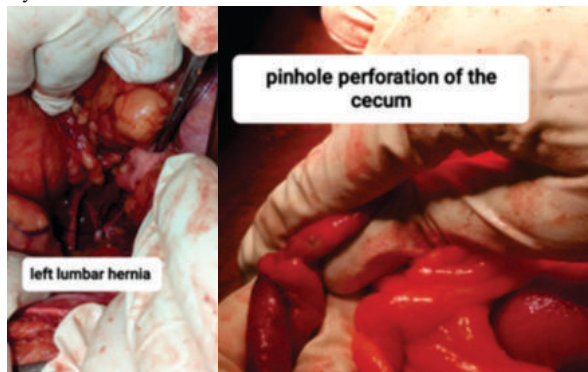


Figure 3 Intraoperative findings

DISCUSSION

Anatomically, Grynfeltt-Lesshaft hernia occurs in the superior lumbar triangle, defined by the 12th rib, erector spinae muscles and posterior border of inferior oblique. It is more common than the Petit (inferior lumbar triangle) hernia.

The majority (55%) of lumbar hernias are primary (spontaneous) with predisposing factors such as old age, chronic lung disease, extremes of weight or muscular atrophy [2]. A further 20% are congenital and the

remaining 25% are secondary (acquired)—resulting from trauma, surgery or infection [2]. In our case, it is likely that the patient developed a spontaneous lumbar hernia 15 years ago, incorrectly diagnosed as a lipoma.

Lumbar hernias most commonly contain omentum or colon but herniation of other organs such as small intestine, spleen or kidney has been reported. Typically, these hernias present with lower back pain and flank swelling. Presentation with bowel obstruction, such as in this case, is rare, and includes only 9% of spontaneous lumbar hernias

Because of its rarity and non-specific presentation, lumbar hernia can be easily confused with other pathologies that present as a superficial flank mass more commonly, for example lipomas. Clinical findings may be misleading as the overlying muscle and subcutaneous tissue can interfere with accurate examination

In the vast majority of reported cases, including ours, a definite diagnosis was made on a CT scan. However, in our case, the presence of the hernia was suggested earlier, on an ultrasound. Potentially, if this had been investigated further at that time, the correct diagnosis could have been made earlier, avoiding the emergency admission with bowel obstruction and allowing for elective repair with a less invasive approach. Furthermore, it illustrates that ultrasound, if interpreted by appropriate specialists, can be used in diagnosis of lumbar hernias, as demonstrated before. This might be of importance in specific situations like pregnancy, young age or in resource deprived areas

Lumbar hernias tend to grow and become more symptomatic. Additionally, as mentioned earlier, there is associated morbidity. Therefore, the general consensus is that these hernias should be repaired surgically, unless patient is too high risk for an anaesthetic [2]. There are no established guidelines regarding the best technique for repair. For non-emergency cases both classic open and laparoscopic approaches have been used successfully. However, in an emergency setting, when there is doubt about bowel viability, laparotomy has been reported. This approach allows resection of non-viable bowel and adequate washout if required. It does; however, increase the risk of certain complications such as adhesional bowel obstruction, as in this case.

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