



**ORIGINAL RESEARCH PAPER**

**Radiodiagnosis**

**MORGAGNI HERNIA IN A 65-YEAR-OLD FEMALE WITH INTRA OPERATIVE FINDING OF LOOSE BODY (BOILED EGG) IN THE PERITONEAL CAVITY, A RARE INCIDENCE.**

**KEY WORDS:**

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**ABSTRACT**

Morgagni hernia is a rare congenital diaphragmatic hernia which are usually asymptomatic. More commonly the defect is present on the right side but here in our case the defect was present on the left side with herniated contents seen crossing over to the right hemithorax which was confirmed radiologically. She underwent hernia repair during which intraoperative presence of loose body (Boiled Egg) was found out. She was discharged following an uneventful procedure and is doing well on follow ups.

**INTRODUCTION:**

Morgagni hernias are one of the congenital diaphragmatic hernias and is characterized by herniation of the contents through the foramen of Morgagni. Morgagni hernias being asymptomatic until adult life may rarely be symptomatic due to complications, such as intestinal obstruction and respiratory distress. They may rarely be associated with mild respiratory distress or gastrointestinal symptoms and in some patients, swallowing disturbance and postprandial discomfort may occur on supine position. Peritoneal loose bodies are rare in occurrence. They are found incidentally during abdominal surgeries by accident and rarely they become symptomatic. The exact etiopathogenesis is not known but the most common origin of these bodies are inflected appendices epiploicae which get detached and lie loose in the peritoneal cavity which get saponified and later calcified.

**CASE REPORT:**

A 65-year-old female presented with vomiting multiple episodes for 1 month. At the time of presentation, the patient was hemodynamically stable. X ray chest showed elevation of the right hemidiaphragm with right basilar atelectasis suggestive of diaphragmatic hernia. On general physical examination patient was afebrile, moderately nourished. Laboratory investigations showed normal haemoglobin value, normal counts, slightly raised blood urea and creatinine and urine examination, and ECG were within normal limit. 2D-ECHO showed poor echo window but rest was within normal limit. USG abdomen showed no significant abnormality. HRCT chest was performed for further evaluation, which revealed a 4.7 x 5.3 cm (AP X TR) sized defect in the anterior aspect of the left hemidiaphragm through which pylorus and antrum of the stomach, transverse colon and intraabdominal fat were seen herniating into the anterior mediastinum. The herniated stomach and large bowel showed normal caliber and enhancement of their walls. No stranding of the herniated fat was noted. No free fluid was seen within the hernial sac. The herniated contents were crossing over to the right hemithorax. Also subsegmental atelectasis is seen in the right middle lobe. Surgical opinion was asked for and decision was taken to operate the patient for surgical repair of the hernia with placement of mesh. Intra operative the surgeons came across a well-defined egg like structure located loosely attached to the mesentery of the large bowel. It was preserved and sent for histopathological examination. The loose body was oval in shape and measured 2 cm in length, 1.5 cm in width. On cut surface it had the appearance of that of a boiled egg with classic peripheral white and central yellow part. Histological examination showed large amount of proteinaceous material with few fibrin strands in the peripheral white part with saponified fat and calcification in the central yellow part. The patient tolerated the procedure well and did well on further visits.

**DISCUSSION:**

The diaphragmatic hernias of Morgagni are the rarest of congenital diaphragmatic hernias, making up 2-3% of cases. The etiopathogenesis consists of herniating of the contents through the foramen of Morgagni. They usually present in childhood with respiratory symptoms. Incidental findings of this condition in adults are less common. Symptomatic adult cases of Morgagni hernias are even rare. Very few present with chest symptoms, the majority present with abdominal pain due to strangulation of the viscera. Of the symptomatic adult cases, the herniated viscera involve omentum, small bowel or stomach. Our case also showed herniation of large bowel and intraabdominal fat. The defect can occur on either side but are commonly seen on the right but in our case the defect was present on the left side with the herniated contents seen crossing over to the right hemithorax. Presence of loose body in the peritoneal cavity was an incidental finding. The exact etiopathogenesis is of its formation is still not very clear. It is believed to form as a result of series of events with torsion of an epiploica, followed by ischemia, saponification and lastly its calcification.

**CONCLUSION:**

This case showed a left sided Morgagni hernia with crossing over of the herniated contents to the right hemithorax with unusual clinical presentation which on overlooking could have lead to life threatening complication and incidental finding of intraperitoneal loose body intra operative.

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