Case Report

Strangulated lumbar hernia: an exceptional case of intestinal obstruction

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ABSTRACT

Lumbar hernia is a rare condition and about 325 cases reported so far, not more than 30 cases of strangulated lumbar hernia have been reported in the surgical literature since 1889. Therefore, diagnosis can be easily misdiagnosed. We present a case of a 75-year-old gentleman, who had come with acute intestinal obstruction with strangulated right inferior lumbar hernia. We did exploratory laparotomy with resection and anastomosis and repair of hernia defect. As per our observation this is 31⁴ reported case of strangulated/obstructed lumbar hernia in literature.

Keywords: Emergency hernia surgery, Lumbar hernia, Strangulation

INTRODUCTION

Lumbar hernia is a rare hernia with approximately only 300 cases reported in literature since it was first described in 1672 by Barbette.¹ Lumbar hernia can be classified into primary or secondary, congenital, or acquired hernia. Due to the rarity of this hernia, complications like strangulation or incarceration are very rarely reported. Therefore, there are no specific guidelines for management of such hernias. To best of our observation, this is 31⁴ case of strangulated/incarcerated lumbar hernia reported in literature so far.¹,4-26

CASE REPORT

A 75-year-old man presented with abdominal distension and vomiting for last 5 days and swelling in right lumbar region since 1 year, which was painful since last 2 days. He was a farmer by occupation, living in a remote area. On physical examination, the patient was dehydrated; abdomen was distended with around 8x9 cm tender irreducible swelling over right lumbar region. He was resuscitated with intravenous fluids. His outside USG report was suggestive of abscess in right lumbar region for which he was referred to our hospital. As the symptoms were suggestive of acute intestinal obstruction, CT abdomen was done which revealed right inferior lumbar hernia just above the iliac crest causing herniation of distal ileal loops.

Diagnosis of right inferior lumbar obstructed hernia with possibility of strangulation was established and the patient was posted for emergency surgery.

Due to suspicion of strangulated hernia, exploratory laparotomy with midline incision was performed. During exploration, omentum and proximal ileal loop was seen herniating through right inferior lumbar hernia defect just above right iliac crest. With gentle maneuver, omentum and ileal loop were reduced back in abdomen. Around 5 cm of ileal loop was gangrenous with small perforation and no signs of viability even after application of warm mop over it for 15 minutes. The gangrenous part was resected and end to end anastomosis was done with absorbable sutures. Hernial sac was removed and cavity was cleaned with thorough saline wash. Hernia defect
was closed with prolene 1-0 by approximating external oblique muscle with latissimus dorsi muscle. Post operatively, patient recovered gradually and was discharged on post operative day 9. Post operative period was uneventful. As of now on 1 year follow up patient is having no recurrence.

DISCUSSION

Lumbar hernia is a rare abdominal hernia. It was first described by Barbette in 1672. The first case was published by Garangeot in 1731. H. Ravaton performed first surgical treatment of strangulated hernia in 1750. First laparoscopic lumbar hernia repair was done by Burick and Parascandola in 1996. Hafner et al stated that general surgeons will get only one opportunity to repair a lumbar hernia during their lifetime due. However, due to
the increased incidence of traumatic etiology and the advances in diagnostic methods available, lumbar hernias are encountered more frequently in current practice. There are two triangles in lumbar region from which lumbar hernias can occur:

Significant advances have been made in the study of colorectal cancer during the last few years. A more thorough understanding of the molecular basis for this disease, coupled with the development of new therapeutic approaches, has dramatically altered the way in which patients are managed. We are in a unique electronic age with access to a plethora of sources of medical information, so the vehicles we use to keep up-to-date must change as well, and this text is no different. In this study patients were below 30 years of age, the incidence rise with advancing age, maximum between 40-60 years of age. There was slight male predominance, 54.28% patients were male and 45.71% were females. The lifetime risk for colorectal cancer is 1 in 18 for men and 1 in 28 for women, but its occurrence under 50 years of age is very low.

The common site of malignancy in the present study is in rectum, and the commonest symptom in our study was bleeding per rectum, and the commonest symptom in our study was bleeding per rectum. The common site of malignancy in the present study is in rectum, is more common in women, and carcinomas of the rectum is more common in men. 70% of patients of the colorectal malignancies were diagnosed clinically by digital P/R examination and proctosigmoidoscopy. This is confirmed by biopsy and histopathological examination. Other investigations were barium enema, USG abdomen, CT scan, CEA and X-ray chest. Lymph node metastasis (17.14%) was better diagnosed on CT scan. MRI may be useful for this purpose as well. PET/CT scans are useful for detecting recurrences and metastatic disease but are probably not necessary as part of the routine initial evaluation.

Patients with Dukes A stage did not receive postoperative chemotherapy and were advised regular follow up. 38 patients received post-operative chemotherapy. 18 patients were given radiotherapy. New evidence suggests a role for anti-inflammatory drugs in the treatment and prevention of colon and rectal cancers. Out of 70 patients over all follow-up of 42 patients (60%) was done. 6 patients died after surgery due to metastatic disease, other were free of disease. Current recommendations are: CEA every 2 months for 2 years then every 4 months for 2 years then annually, colonoscopy within the first 2-3 months then annually, LFTs every 3 months for 2 years then every 6 months for 2 years then annually and CXR every 6 months for 3 years then annually.

**Limitations**

In case of colorectal malignancies, the stage wise distribution of the disease (in percentage) observed by other authors is shown.

**CONCLUSION**

The management of colorectal cancer has progressed over the past few decades because of many advances, including those in genetics, pathology, imaging, medical oncology, radiation oncology, and surgery. Undoubtedly, the management of patients afflicted with colorectal cancer will evolve as advances continue to be made in the multiple disciplines that contribute to the diagnosis and treatment of colorectal cancer.

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**REFERENCES**
