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Case Report

An uncommon hernia with an uncommon presentation: a case report on obturator hernia with ileal transection

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ABSTRACT

Obturator hernia is a rare pelvic hernia with an incidence of 1%. It is the protrusion of abdominal content through the obturator foramen. Here we report a rare case of obturator hernia in thin, emaciated female patient of age 60 years with complication of ileal transection, hence emphasizing early presentation and diagnosis.

Keywords: Obturator hernia, Perforated obturator hernia, Ileal transection

INTRODUCTION

Obturator hernias are rare and account for less than 1% of all abdominal wall hernias.[1] It is a diagnostic challenge in the emergency department since the signs and symptoms are non-specific. It often occurs in elderly, emaciated and chronically ill women (Little old lady's hernia). It usually presents with acute intestinal obstruction.

Obturator hernias occur more often on the right side than the left side because the left side is covered by the sigmoid colon.[3,4] Delayed diagnosis of this condition usually leads to a high mortality rate.[2] Late presentation and delated diagnosis often leads to complications such as perforation and peritonitis.

Here we reported a case of obturator hernia with ileal transection, which was due to delayed presentation.

CASE REPORT

A 60/F weighing 40 kg, with BMI 16, emaciated and thin, presented with 7 days history of vomiting and abdominal distension, and obstipation for 4 days. Patient was a known diabetic on irregular medications. Examination revealed distended abdomen and signs of peritonitis with a positive Howship-Romberg sign. External hernial orifices were free with no visible swelling. Digital rectal examination revealed absent fecal staining with collapsed rectum. Clinical diagnosis of acute intestinal obstruction was made and investigations were proceeded. Pre-operative CT abdomen revealed right obstructed obturator hernia (Figure 1).

Patient was immediately shifted to OR. Emergency laparatomy was done and 2 litres of bilious fluid drained with extensive flakes over abdomen. About 60 cm proximal to ileocecal junction loop of ileum was entering right obturator foremen (Figure 2) with transection of ileum (Figure 3).

Thorough wash given. Transected part of ileum was resected. Since patient general condition was poor and in view of peritonitis a double barrel ileostomy was done. Primary closure of defect in obturator foremen was done with non absorbable suture (Figure 4 and 5).

Patient was kept on artificial ventilation for 2 days. After recovery of metabolic acidosis, dyselectrolemia and hypotension patient weaned off from artificial ventilation and extubated on post operative day 3. Stoma started functiong in post operative day 2. Patient was started on

orals on day 3. After improving the nutrional status for a period of 3 months stoma reversal was done. Patient recovered well.

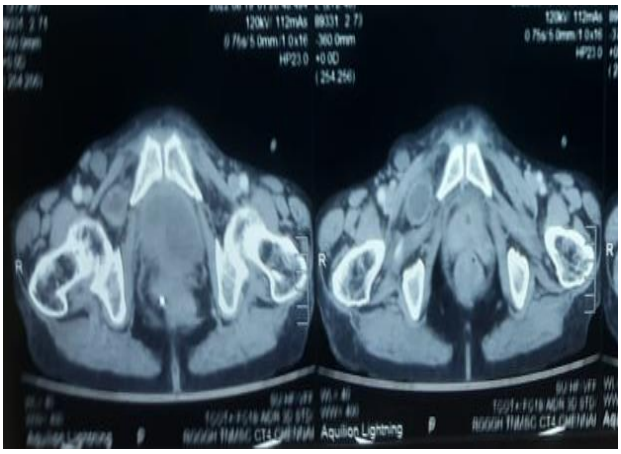

Figure 1: Pre-operative CT-abdomen.

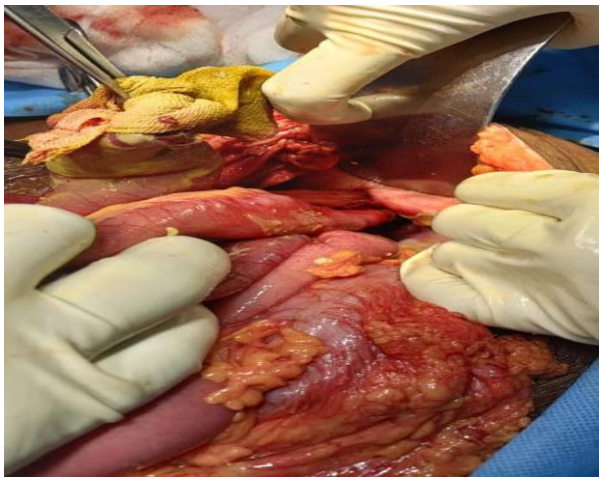

Figure 2: Loop of ileum entering obturator foremen.

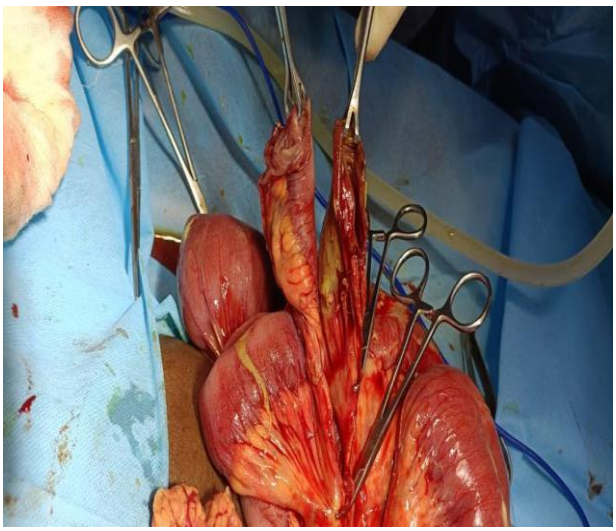

Figure 3: Transected ileum recovered from obturator foremen.

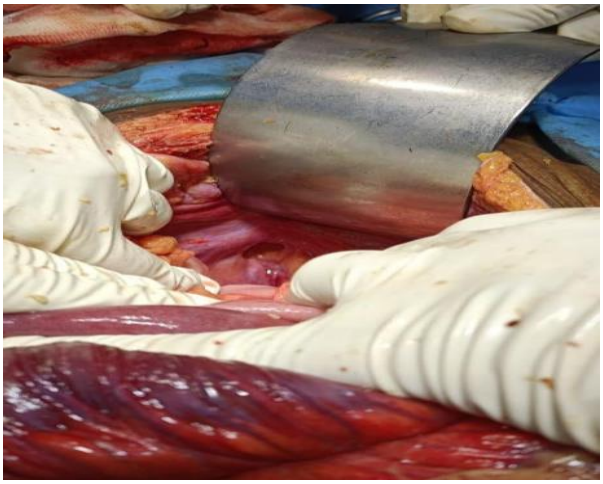

Figure 4: Obturator foremen.

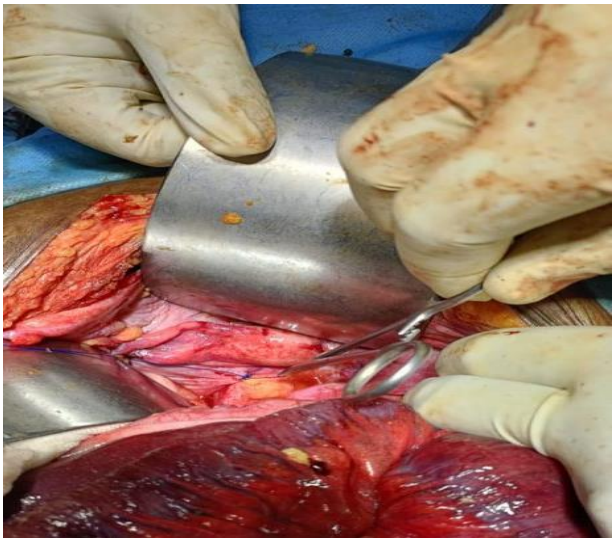

Figure 5: Primary closure of defect in obturator foremen.

DISCUSSION

Obturator hernias are exceedingly rare and can be difficult to diagnose. The major risk factors for obturator hernia are chronic obstructive pulmonary disease, chronic constipation and ascites.[6] Major clinical symptoms are due to intestinal obstruction like abdominal pain, distension, nausea, vomiting and constipation. They may also have recurrent attacks of intestinal obstruction in the past with or without a palpable mass in the groin.[7]

The higher occurrence in female is due multiple factors like, broader triangular pelvis and greater transverse diameter, steeper oblique orientation of obturator canal, and an increase in laxity of pelvic tissues. It affects women of around 70-90 years of age, the reason being attributed to atrophy of the pre-peritoneal fat around the obturator vessels in the canal thereby predisposing hernia formation and hence the name 'little old woman's hernia'.[8]

There are two physical signs that can aid in diagnosis of obturator hernia: Howship-Romberg sign and Hannington-Kiff sign. The Howship-Romberg sign presents with inner thigh pain that is worsened by adduction, extension, and medial rotation of the thigh while flextion tends to relieve symptoms. This is due to compression of the cutaneous branch of the obturator nerve. This sign, however, is estimated to be present in less than 50% of cases.[9] The Hannington-Kiff sign occurs when there an intact patellar reflex with a concurrent loss of the thigh adductor reflex. This is due to obturator nerve compression causing weakness of the adductor muscles.[10] This sign is considered to be more specific; however, it is less commonly seen.

In suspected cases imaging investigation with CT abdomen is done early since most of the obturator hernia presents with nonspecific symptoms and signs without and visible or palpable swelling. Delayed investigation and diagnosis can increase complications and mortality.

Surgical repair is the mainstay of treatment. Repair is performed with non-absorbable sutures. It can be performed either in open or laparoscopic approach. In uncomplicated obturated hernias, laparoscopic methods tends to be beneficial since most of the cases have Ritcher's type of hernia in which only a part of circumference of bowel is involved causing strangulation. Laparoscopic approach may be more beneficial for patients, especially in the elderly, given that fewer postoperative complications are seen with laparoscopic repair.[11,12]

Eventhough our patient recovered well, early presentation to hospital could have avoided complications perforation and peritonitis. Hence we emphasize the need for early diagnosis and early intervention.

CONCLUSION

Obturator hernia, a rare cause of mechanical intestinal obstruction can be easily missed if proper suspicion and prompt investigations are not carried out and more so due to very non specific symptoms and meagre clinical signs. It should be amongst the differential diagnosis in cases of acute intestinal obstruction with unknown cause especially in the elderly age group.

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