

Letter to the Editor

Intestinal Obstruction Secondary to Ventral Hernia

Sahu et al. Intestinal Obstruction Secondary to Ventral Hernia

Kamal Kant Sahu, Akil Adrian Sherif, Ajay Mishra, Sunita Vyas

Clinic of Internal Medicine, Saint Vincent Hospital, Worcester, United States

Address for Correspondence: Kamal Kant Sahu, Clinic of Internal Medicine, Saint Vincent Hospital, Worcester, United States

e-mail: KamalKant.Sahu@stvincenthospital.com

Received: 25 August 2017

Accepted: 29 June 2018

DOI: 10.4274/balkanmedj.galenos.2019.2018.12.47

Cite this article as:

Sahu KK, Sherif AA, Mishra A, Vyas S. Intestinal Obstruction Secondary to Ventral Hernia. *Balkan Med J*

Dear Editor,

Zheng et al recently mentioned about bowel obstruction secondary to obturator hernia (1). We would like to share our similar experience. Aim of our paper is to enhance the fund of knowledge of Balkan MJ readers about the abdominal hernias, their spectrum of presentation (SAIO, strangulation etc) and management strategies- medical, surgical intervention (open vs laparoscopic).

A 86-year-old diabetic lady presented to emergency services for the complaints of abdominal pain associated with nausea and vomiting. Patient recalls multiple visits to urgent care for similar complaints and abdominal bulge which she started noticing for last few months. Patient had abdominal surgery approximately thirty years ago for acute cholecystitis. In the emergency room (ER), the patient's blood pressure was 116/57mmHg, pulse rate was 62 per minute, respiratory rate was 18 per minute, temperature was 96.6 F and O2 saturation 100% on room air. Abdominal examination showed a midline scar and an abdominal bulge in the epigastric region which was soft and non-tender on palpation. Skin over the bulge was normal in appearance and normothermic to touch (Figure 1A, B). Laboratory examination showed a sodium level of 137 mmol/L, a potassium level of 4.1 mmol/L, a chloride level of 98 meq/L, a bicarbonate level of 22 meq/L, a blood urea nitrogen level of 19 mg/dL, a creatinine level of 1.01 mg/dL, a Hb level of 12 gm/dL, a platelet count of 21000 cells/mm³, a total leucocyte count of 6100 cell/mm³. CT scan of abdomen/pelvis showed dilated small bowel loops up to ventral hernial sac (Figure 1C, D, E, F). Considering sub-acute intestinal obstruction secondary (SAIO) secondary to ventral hernia, patient was put on an NG tube 16FR, through the right naris, and gastric contents were removed via suction. Over next 48 hours, patient was medically managed with IV normal saline and anti-emetics. She gradually started tolerating oral fluids after which NG tube was removed. Surgical team intervened with laparoscopic mesh repair.

In our case, SAIO occurred secondary to abdominal adhesions post cholecystectomy. Rectus sheath hematoma, abdominal wall abscess, lipoma and urachal anomalies are the other commonly encountered differentials (2). CT abdomen in most cases is helpful to know the extent of disease, bowel lumen dimensions, adhesions, congenital anomalies etc.

Owing to the chronicity and indolent course, hernias are usually silent till they start producing obstructive symptoms or septic features secondary to luminal strangulation. Both Zheng *et al's* case and our patient were old and had similar symptoms. In our case, patient did not have strangulation which gave us window period to stabilise the patient first. We followed with the surgical team who operated the patient soon with laparoscopic mesh repair. Contrarily, in Zheng's case, patient had immediate worsening complications secondary to strangulation which required emergent open surgery.

Abdominal pain is one of the most common scenarios faced in the ER. Combining the two cases together, we strongly believe that readers would have a good understanding about the varied presentations and treatment strategies (3). If there is ongoing sepsis, lactic acidosis, skin discoloration, high chances of hernia being strangulated mandating urgent surgical exploration.

REFERENCES

1. Zheng L, Lin W, Guo J, Chen S. Obturator Hernia: A Rare Cause of Small Bowel Obstruction. *Balkan Med J* 2018; 35:440-441.
2. Henriksen NA, Bisgaard T, Andersen HF, Jørgensen LN, Helgstrand F. [Surgical treatment algorithm for ventral hernias]. *Ugeskr Laeger*. 2018 Sep 10;180(37).
3. Li BG, Gong DH, Miao JC, Nie XY, Qin CF. [Totally endoscopic sublay repair (TES)--a novel approach to repair midline ventral hernia]. *Zhonghua Yi Xue Za Zhi*. 2018 Sep 25;98(36):2933-2936.

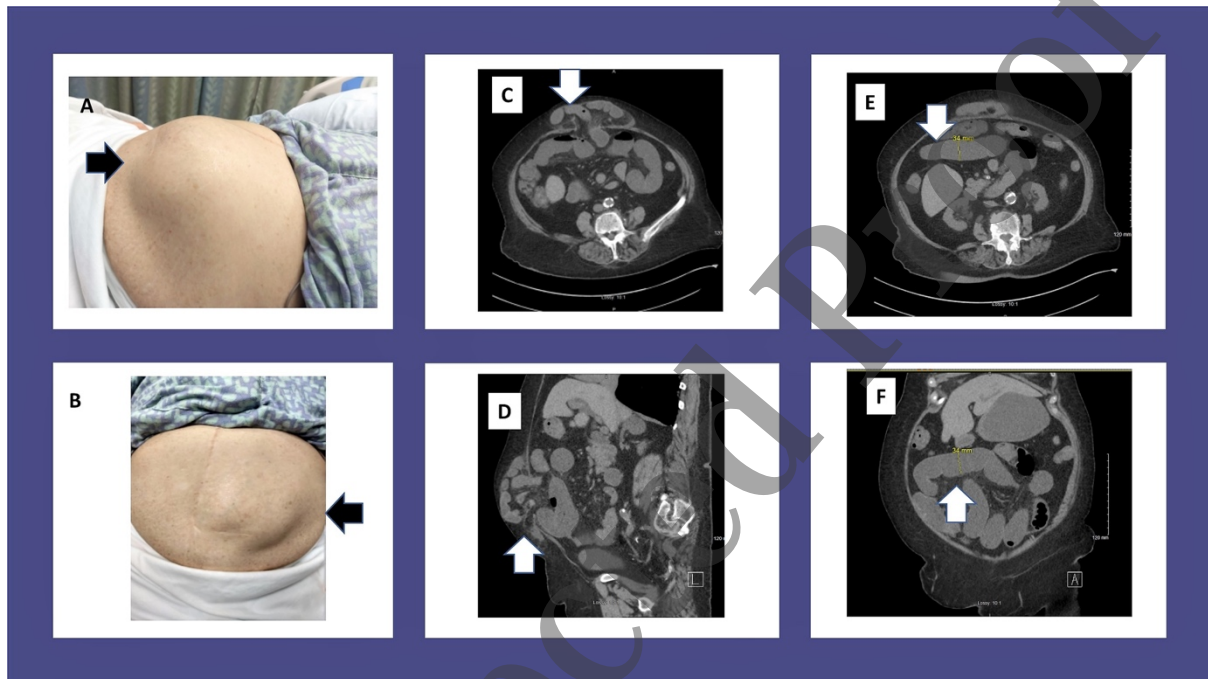


FIG. 1. a-e. (Lateral aspect) (a) and (Anterior aspect) showing a abdominal bulge involving the epigastrium region (b), (axial) (c), (sagittal) showed dilated bowel loops up to the ventral hernial sac (d), (axial) (e), (coronal) showing small bowel loop dilation of approximately 3 cm, as indicated (f).