

Bowel obstruction on internal hernia

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ABSTRACT

Internal abdominal hernias are an uncommon etiology of intestinal obstruction.

They are responsible for 0.2 to 5.8% of small bowel obstructions in published series¹.

Here, we report the case of a 27-year-old patient who presented to the emergency department with an occlusive syndrome. On examination, the abdomen was tympanically distended, and on imaging, the bowel was distended upstream of a thickening of the last ileal loop.

The patient underwent emergency surgery, with exploration revealing an incarcerated bowel loop 40 cm from the ileocecal junction in the retrocecal fossa, indicative of an internal hernia with 4 cm of proximal bowel distension. The loop was successfully reduced and found to be viable.

key words: small bowel, intestinal occlusion, retrocecal internal hernia.

Introduction:

Internal abdominal hernias are an unusual cause of intestinal obstruction.

they are responsible for 0.2 to 5.8% of small bowel obstructions in published series¹.

Diagnosis of these hernias is difficult, both for the clinician and the radiologist. This is why the risk of strangulation and the mortality rate remain high.

There are two categories of internal hernia

The first is hernias developed in a normal or para-normal orifice of the peritoneum, such as hernias of the omental foramen, paraduodenal hernia, which is the most frequent, pericaecal hernia and intersigmoid hernias.

The second is hernias developed through an abnormal orifice in the peritoneum (transmesenteric trans-mesocolic and trans-omental hernia, broad ligament hernia, and falciform ligament hernias).

We report a case of a strangulated retro caecal internal hernia responsible for acute intestinal obstruction in a young patient

Case

Patient aged 27, followed for pulmonary tuberculosis on antibacillary treatment at day 8 of treatment.

Presented to emergency department with occlusive syndrome consisting of cessation of bowel movements and gas associated with bilioalimentary vomiting.

Clinical examination revealed à tympanic distended abdomen, free hernial orifices Rectal examination without anomaly.

ABDOMINOPELVIC TDM that revealed a distended ileum with hydroaeric levels measuring 7cm in maximum diameter at ileal level, upstream of a circumferential, regular, stenosing parietal thickening of the last ileal loop, measuring 11mm in maximum thickness, Associated with this is another ileal parietal thickening, circumferential, regular, non-stenosing, measuring 7mm in maximum thickness, No signs of digestive distress, Collapsed colon.

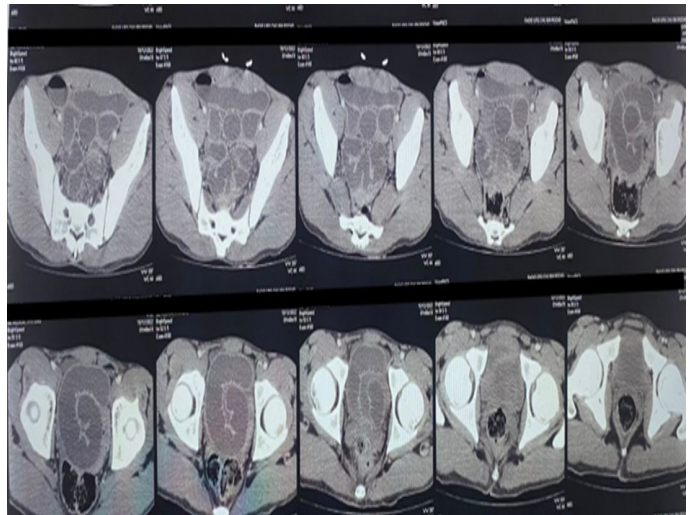
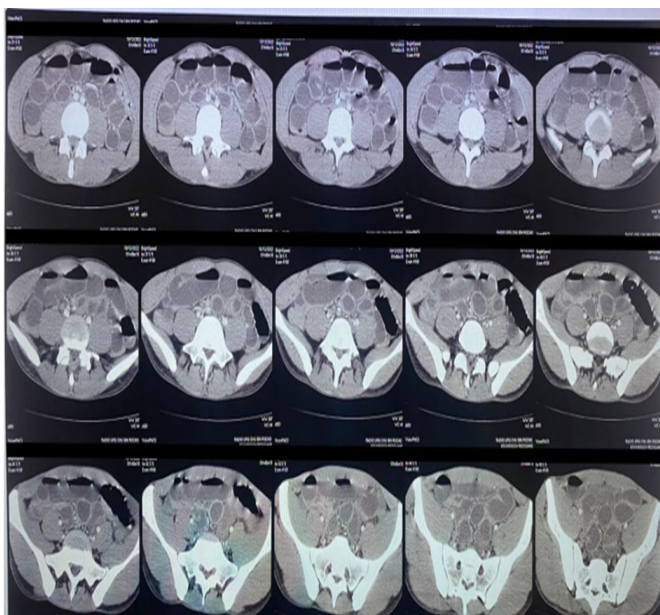


Figure 1 et 2: hydroaeric levels on scanner

The patient was admitted to the operating theatre as an emergency patient. the operation was performed by laparotomy, On examination Presence of a bowel loop 40 cm from the ileocaecal junction, incarcerated in the retrocaecal fossa, creating the appearance of an internal hernia with 4 cm of upstream bowel distension.

The incarcerated loop was reduced and was viable, sectioning of the external parietocaecal ligament and detachment of the ascending colon.

Post-operative follow-up was straightforward: the patient had resumed transit on post-op day 1 and was discharged on post-op day 2.

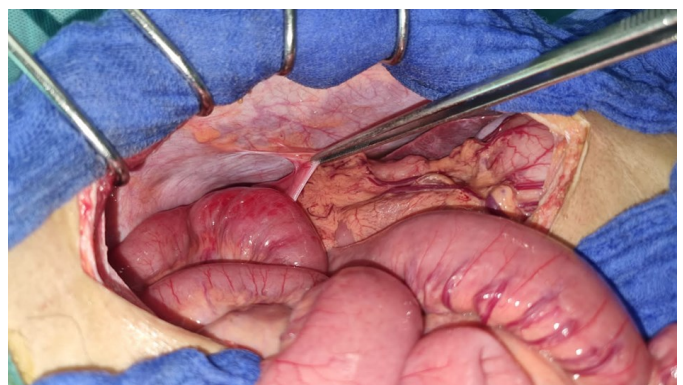


Figure 3: the seat of the bowel incarceration

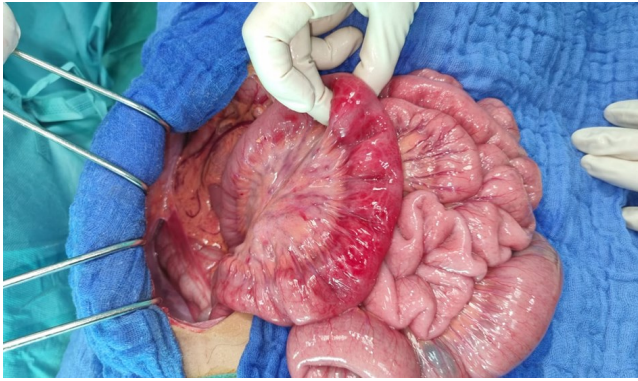


Figure 4: the incarcerated intestinal loop

Discussion :

An internal abdominal herniation is the protrusion of an abdominal organ through a normal or abnormal mesenteric or peritoneal aperture².

They may be revealed in the acute setting of intestinal obstruction, and account for 0.2 to 5.8% of all bowel obstructions³.

They are generally diagnosed intraoperatively, although preoperative diagnosis is possible and difficult due to their asymptomatic nature⁴.

Pericaecal hernias account for 13% of internal hernias, and are generally congenital in origin, revealing themselves in adulthood⁵.

The approach is usually a median laparotomy, but laparoscopy is also possible in the case of a flat abdomen⁶.

Exploration in the case of retrocaecal hernias reveals an anteriorly projected cecum, behind which the terminal ileum engages in a peritoneal recess⁷.

The surgical procedure most often involves reduction of the strangulated loop, but in cases of intestinal distress, anastomotic resection may be opted for⁸.

Treatment of the hernia sac is very important intraoperatively to avoid recurrence. If the sac is large, a right coloparietal detachment is necessary; otherwise, small hernia sacs can be obliterated with simple stitches⁴.

Conclusion:

Internal hernia is a rare pathology: retrocaecal hernias account for 13% of internal hernias. Their diagnosis is difficult and is most often made intraoperatively, but should not be ruled out in the event of an occlusive syndrome in a never-operated abdomen.

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