LUMBAR HERNIA - A RARE ABDOMINAL WALL DEFECT

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ABSTRACT

Introduction: Lumbar hernia is a rare abdominal wall defect and clinical suspicion is necessary for diagnosis. We present a case of Lumbar hernia treated successfully at our institution.

Case report: We report the case of 55 year old female with a right superior lumbar hernia (Grynfeltt hernia). The diagnosis was made clinically and confirmed by CECT. Mesh hernioplasty was done. The patient was free of recurrence at 4 months after the operation.

Conclusion: A lumbar or flank mass should always raise suspicion of a lumbar hernia. Ultrasound and computed tomography may confirm the diagnosis. Adequate surgical treatment should be planned on the basis of etiology and hernia size. Both open and laparoscopic techniques can be used with good results.

INTRODUCTION

Lumbar hernias are quite uncommon as compared to other ventral abdominal wall hernias, accounting for less than 1.5% of all abdominal hernias, with fewer than 300 cases reported over the past 300 years. About 25% of all lumbar hernias have a traumatic etiology. Though rare, lumbar hernias are prone to incarceration and strangulation. Lumbar hernias are rare defects involving two weak areas of the posterolateral abdominal wall: the superior lumbar triangle of Grynfeltt, which is the most common site, and the inferior lumbar triangle of Petit. In large congenital or postsurgical hernias the defect wall can affect the entire lumbar region. Lower-back pain is the most common symptom although small hernias may be asymptomatic except for a palpable mass. Adequate surgical treatment depends largely on the type and size of the hernia and both open and laparoscopic techniques can be used with good results.

Case report

A 55 year old female presented to the surgical OPD with complains of gradually progressive swelling in right lumbar region associated with dull aching pain for last 1 year. There was history of having undergone laparoscopic cholecystectomy 5 years back and Abdominal/vaginal hysterectomy 24 years back. Patient was a known case of Diabetes Mellitus and Hypertension and was on regular medication. On examination, there was a single oval swelling of 12 x 10 cms arising from the right superior lumbar triangle. It was non tender, reducible and expansile on coughing. The opposite side lumbar region and other hernial orifices were normal. USG right lumbar region revealed abdominal wall defect in right lumbar region measuring 2.5 cm. CECT of right lumbar region confirmed the presence of right superior lumbar hernia containing retroperitoneal fat. She was accepted for anaesthesia under ASA II and consent was taken.

Per-operatively, the herniated fatty mass was isolated and reduced in the abdomen. The abdominal wall defect was 3.5 cm in diameter and was repaired with interrupted No 1 polyamide sutures. Onlay prolene mesh hernioplasty with a 15 x 7.5 cm mesh was done. Skin and subcutaneous tissues were closed in layers after placing an 18 Fr closed suction drain. Drain was removed two days post operatively and the patient was discharged on the 4th post operative day, with eventful recovery. Sutures were removed in OPD on 10th post operative day. The patient is doing well on follow up after 4 months with no recurrence.

DISCUSSION

These occur more commonly in males and are twice as common on the left as compared to the right side. Patients are...
usually between 50 to 70 years old. They are classified as:

a) Congenital (20%), generally associated with other malformations, or
b) Acquired (80%), manifesting in adults spontaneously (55%) or secondary to trauma or surgical incision (25%).

Patients are usually asymptomatic but may present with complaints of backache, flank pain or a dragging sensation. These hernias have a natural history of a gradual increase in size. Anamnesis is helpful for diagnosis in post-traumatic or postsurgical lumbar hernias while in spontaneous adult hernias, misdiagnosis may occur. Clinical suspicion is fundamental to guide imaging diagnosis because hernial sac may mimic a lipoma. Computed tomography (CT) or magnetic resonance imaging (MRI) in patients with a suspected hernia can confirm the diagnosis adding information on parietal defect size, hernia contents and muscular trophism.

The goal of hernia repair is to eliminate the defect and to reconstruct an elastic and firm abdominal wall that will withstand the stress of daily physical activities. A lumbar hernia should be repaired surgically, as it is prone to both obstruction and strangulation. Adequate surgical treatment depends largely on the type and size of the hernia. A wide variety of techniques have been described for repair of lumbar hernias. These include anatomical closure, overlapping of the aponeuroses, use of musculofascial flaps, prosthetic meshes and laparoscopic mesh repair in case of uncomplicated lumbar hernias. Currently, extraperitoneal mesh repair is considered the optimal treatment for isolated unilateral lumbar hernia. Laparoscopic repair has been used successfully in different reports with less post-operative pain, shortened hospital stay and better cosmetic and functional results.

CONCLUSION

Although a rare pathology, knowledge of lumbar hernia is important to avoid misdiagnosis. In particular, a lumbar or flank mass should always raise suspicion of a lumbar hernia. Ultrasound and CT imaging may confirm the diagnosis. Appropriate surgical treatment should be planned on the basis of etiology and hernia size.

References


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