

Epigastric hernia with sac- A case report

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Abstract

Hernias of the Linea Alba with real peritoneal sac are usually uncommon. An epigastric hernia arises through the Linea Alba anywhere between the xiphoid process and the umbilicus. Usually, epigastric hernia presented with preperitoneal fat for which repair has been done, here we presented a case of epigastric hernia with peritoneal sac with Omentum as content for which we did repair along with only Meshplasty.

Keywords: Epigastric hernia, Sac, Omentum

Introduction

Hernia is derived from the Latin word for ‘rupture’. A hernia is defined as an abnormal protrusion of an organ or tissue through a defect in its surrounding walls. Abdominal wall hernias occur only at sites at which the aponeurosis and fascia are not covered by striated muscle. These sites most commonly include the inguinal, femoral, and umbilical areas, Linea Alba, lower portion of the semilunar line, and sites of prior incisions. An epigastric hernia arises through the midline raphe (Linea Alba) anywhere between the xiphoid process and the umbilicus, usually midway.

Case report

A forty-two-year-old male patient came with history of swelling over the anterior abdominal wall in the epigastric region since 6 months. He also gave a history of increase in size of the swelling with coughing/straining whereas reduces by manually. Physical examination done which suggests a swelling of size 4x3 cm over the epigastric region with regular margin and no any skin changes/ surrounding edema, which can be reduced manually. Ultrasonography done which suggests of a hernia with 20mm gap defect. Later patient was planned for elective surgery and all those necessary preoperative preparations have been done. On OT table patient was induced and after painting and draping, midline vertical incision made over the epigastric region. On exploration there was a gap defect of about 2 cm on the rectus sheath with a hernial sac found [Figure 1]. Dissection done and sac was opened and found to have Omentum [Figure 2] as content and later contents reduced followed by trans fixation and excision of redundant sac done and defect in the rectus sheath has been closed. A polypropylene mesh of size 10x15 cm² has been placed by only technique and postoperatively patient was healthy and uneventful.



Figure 1: Hernial sac with 20 mm gap defect



Figure 2: Hernial sac with Omentum as content

Discussion

Epigastric hernia is a rare form of ventral abdominal hernia and accounts for 0.4–1.5% of all abdominal hernias¹. Approximately 3% to 5% of the population has epigastric hernias. Epigastric hernias are two to three times more common in men. These hernias are located between the xiphoid process and umbilicus and are usually within 5 to 6 cm of the umbilicus². The defects are small and often produce pain out of proportion to their size because of incarceration of preperitoneal fat. They are multiple in up to 20% of patients and

approximately 80% are in the midline. It has been hypothesised that the defect occurs at the site where small blood vessels pierce the Linea alba or, more likely, that it arises at weaknesses due to abnormal decussation of aponeurotic fibres related to heavy physical activity³. Epigastric hernia defects are usually less than 1 cm in maximum diameter and commonly contain only extraperitoneal fat which gradually enlarges, spreading in the subcutaneous plane to resemble the shape of a mushroom. When very large they may contain a peritoneal sac but rarely any bowel. Repair usually consists of excision of the incarcerated preperitoneal tissue and simple closure of the fascial defect, similar to that for umbilical hernias. Small defects can be repaired under local anesthesia. Uncommonly, these defects can be sizable, can contain Omentum or other intra-abdominal viscera, and may require mesh repairs, like in our case.

Conclusion

Very small epigastric hernias have been known to disappear spontaneously, probably due to infarction of the fat. Small to moderate-sized hernias without a peritoneal sac are not inherently dangerous and surgery should only be offered if the hernia is sufficiently symptomatic. In larger hernias and when a peritoneal sac is present, the surgical approach would be preferred and option will be mesh repair. The most common cause of ‘recurrence’ is failure to identify a second defect at the time of original repair.

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