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Case Report:
Spontaneous Evisceration of an Incisional Hernia Presenting One Year After Primary Surgery.

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Abstract: Spontaneous evisceration is a rare complication associated with incisional hernia which demands an emergency surgery. A few cases have been reported on this. We report a spontaneous evisceration of bowel with strangulation which was managed by bowel resection and anastomosis and anatomical repair of incisional hernia.

Key Words: Incisional hernia; Spontaneous rupture; Bowel resection

Introduction:

Incisional hernia is reported to have an incidence of 20% of patients undergoing laparotomy, they occur after any type of incision but the highest incidence is seen with midline and transverse incisions.[1] Spontaneous rupture is a rare complication of incisional hernia and very few cases have been reported.[2-4] We report a case of spontaneous rupture of incisonal hernia in a 50 years old female who underwent laparotomy for carcinoma endometrium one year back.

Case Report:

A 50 years old female presented as an emergency with burst abdomen and evisceration of bowel following bending for prayer. She had undergone hysterectomy and pelvic lymphnode dissection with midline abdominal incision about one and half years back for carcinoma endometrium. She had a BMI of 30. She defaulted for adjuvant therapy and was lost for follow up since then.

On examination her hemodynamic status was stable. Examination of abdomen revealed eviscerated small bowel with gangrenous loop.

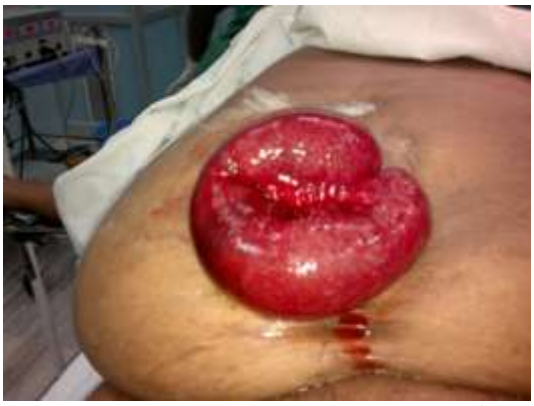
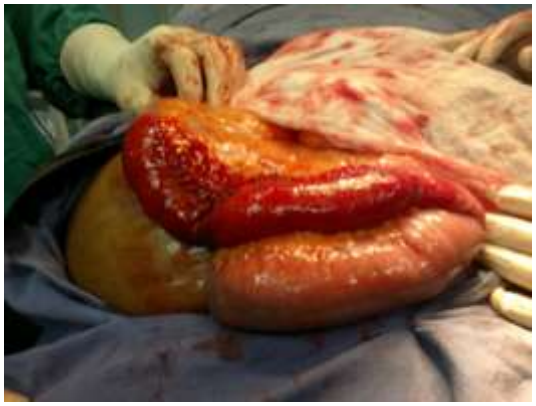


Figure 1: Gangrenous small bowel through the defect

She was posted for emergency laparotomy. Per operative findings revealed about 8 cm rectus sheath defect with herniated bowel and dehiscence of skin with protruding bowel above the skin. Bowel loop protruding from the skin had become gangrenous because of compression of the mesentry. Gangrenous small bowel was resected and end to end anastomosis done. Anatomical repair of the hernia was done with intraabdominal and subcutaneous drains. Excess of skin and subcutaneous tissue was resected.

Postoperative period was uneventful except 3cm marginal flap necrosis, which was debrided and secondary suturing done. Patient was asymptomatic till 2 months on follow up.



Figures 2, 3: Peroperative photographs showing eviscerated gangrenous bowel and anastomosed bowel.

Discussion:

Spontaneous rupture is more commonly reported in incisional hernia.[2] Complications of incisional hernia include irreducible hernia with obstructed, incarcerated and gangrenous bowel, but spontaneous rupture is a rare complication and rarely seen in incisional hernia [3] and a very few cases have been reported.[3-5]

Delay in treatment of incisional hernia with large hernia sac and thin avascular atrophic skin may result in necrosis and rupture of the overlying skin which may be precipitated by postures that cause a sudden increase in abdominal pressure.[6,7] Factors contributing to spontaneous rupture include coughing, lifting heavy weight, straining at defecation and micturition or it may develop gradually by forming an ulcer at the fundus of the hernia. Other factors that predispose rupture are friction by the patient's clothes, lack of adhesion between the bowel and hernia sac.[6,8] Rupture is an emergency indication for surgery to cover bowel and to prevent strangulation. In our case bending posture increased intraabdominal pressure causing bowel evisceration. The skin opening acted as a constricting agent and caused bowel strangulation.

In view of strangulated bowel we opted for anatomical repair of rectus sheath with bowel resection and anastomosis. Intraabdominal drain was kept for bowel anastomosis. If the general condition of the patient is good with no gangrenous bowel it can be managed by primary mesh repair or closure of the skin followed by mesh repair.[9]

Conclusion: Spontaneous evisceration is a rare complication of incisional hernia usually seen in long standing neglected hernias. Timely incisional hernia repair prevents the complications associated with an emergency surgery.

References:

1. Zinner MJ, Schwartz SI, Ellis H. Incisions, Closures, and management of the wound. Maingot's abdominal surgery. Vol. 1. 10. USA: Appleton and Lange; 1997. p. 423.
2. Singla SL, Kalra U, Singh B, Naraula S, Dahiy P. Ruptured incisional hernia. *Trop Doct.* 1997;27(2):112–113.
3. Aggarwal PK. Spontaneous rupture of incisional hernia. *Br J Clin Pract.* 1986;40(10):443–444.
4. Hartley RC. Spontaneous rupture of incisional hernia. *Br J Surg.* 1961;49:617–618.
5. Ogundiran TO, Ayantunde AA, Akute OO. Spontaneous rupture of incisional hernia—a case report. *West AfrJ Med.* 2001;20(2):176–178.
6. Hamilton RW. Spontaneous rupture of incisional hernia. *Br J Surg.* 1966;53:477–479.
7. Mudge M, Hughes LE. Incisional hernia: a 10 year prospective study of incidence and attitudes. *Br J Surg.*1985;72:70–71.
8. Martin J, Kalpana M, Rajeshwara KV. Spontaneous rupture of incisional hernia. *Indian J Surg.* 2010;73(1):68-70.
9. Sagar J, Sagar B, Shah DK. Spontaneous rupture of incisional hernia. *Indian J Surg.* 2005;67(5):280–281.