Strangulated obturator hernia

Rahul Gupta,[1] Harjeet Singh,[1] Mandeep Kang,[2] Rajinder Singh[1]

[1]Department of General Surgery, Postgraduate Institute of Medical Education and Research, Chandigarh, India
[2]Department of Radiology, Postgraduate Institute of Medical Education and Research, Chandigarh, India

Correspondence to
Dr Rahul Gupta,
rahul.g.85@gmail.com

Accepted 2 November 2014

DESCRIPTION

A frail 60-year-old woman presented with a 5-day history of pain in the abdomen, constipation, vomiting and abdominal distension. There was no history of surgery or tuberculosis. On examination, the abdomen was distended and non-tender. The hernial sites were normal. On auscultation, hyperperistaltic bowel sounds were present. On X-ray of the abdomen there were multiple air fluid levels. Contrast-enhanced CT of the abdomen and pelvis showed right-sided obturator hernia (arrow) containing ischaemic small bowel loops with intestinal obstruction (figure 1). At emergency laparotomy, the terminal ileum was found to be entering the right obturator foramen with gross dilation of proximal bowel loops (figure 2). On reduction of the hernia, the herniated bowel loop was found to be gangrenous; it was resected and primary anastomosis was performed. The hernial sac was also identified in the obturator region on the contralateral side (figure 3).

Obturator hernia is a rare type of abdominal wall hernia accounting for 0.05–0.4% of all cases.[1] It is seen most commonly in frail, elderly multiparous females.[1] Most cases present with acute intestinal obstruction and are diagnosed intraoperatively.[2] The classical 'Howship-Romberg' and 'Hannington-Kiff' signs of obturator hernia are uncommon and often overlooked.[1] CT of the abdomen has accuracy of 80% for making preoperative diagnosis.[1] Treatment consists of reduction of hernial contents with primary closure of hernial defect with simple interrupted non-absorbable sutures, which can be performed at laparotomy or by a laparoscopic approach based on the clinical condition of the patient.[3]

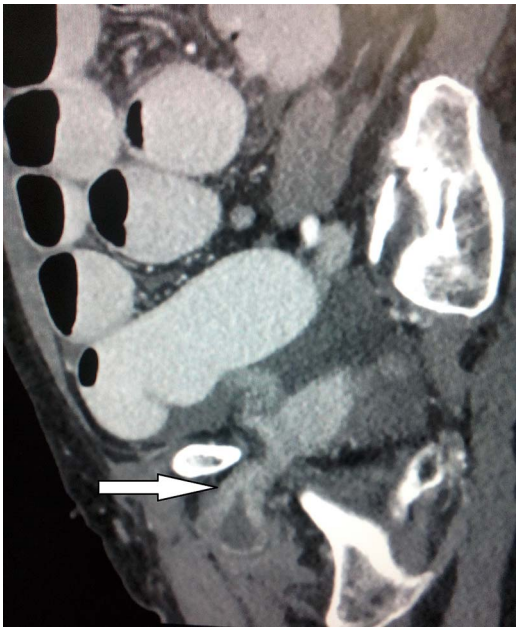

Figure 1 Contrast-enhanced CT of the abdomen and pelvis showing a right-sided obturator hernia (arrow) containing ischaemic small bowel loops with intestinal obstruction.

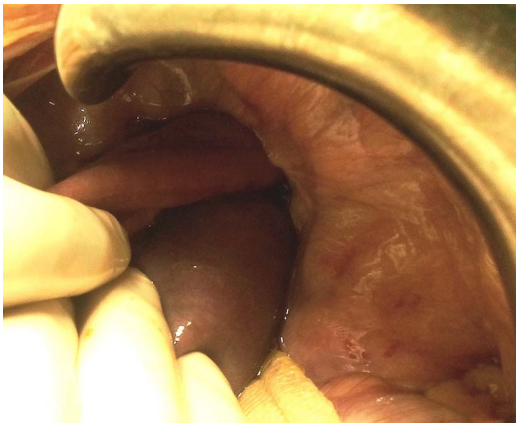

Figure 2 Intraoperative photograph showing terminal ileum enter the right obturator foramen with gross dilation of proximal bowel loops.

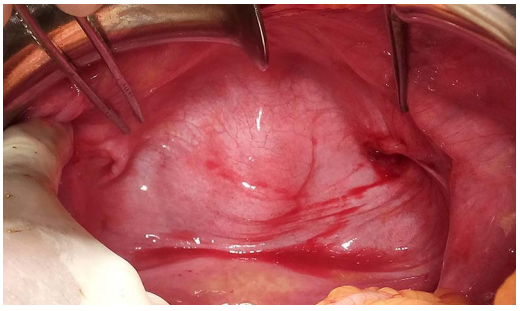

Figure 3 Intraoperative photograph showing presence of obturator hernial sac on both sides.

Learning points

- Obturator hernia should be suspected in frail elderly women presenting with acute intestinal obstruction.
- CT of the abdomen and pelvis is the imaging modality of choice for preoperative diagnosis of obturator hernia.
- Most of the cases can be managed by reduction of hernial contents with primary closure of hernial defect.

To cite: Gupta R, Singh H, Kang M, *et al*. *BMJ Case Rep* Published online: [*please include* Day Month Year] doi:10.1136/bcr-2014-207071

Contributors RG was involved in writing, editing and approval of the manuscript. HS, MK and RS were involved in editing and approval of the manuscript.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

1 Chang SS, Shan YS, Lin YJ, *et al*. A review of obturator hernia and a proposed algorithm for its diagnosis and treatment. *World J Surg* 2005;29:450–4.
2 Gray SW, Skandalakis JE, Soria RE, *et al*. Strangulated obturator hernia. *Surgery* 1974;75:20–7.
3 Zeeshan S, Muhammad K, Chughtai J, *et al*. Strangulated obturator hernia—an unusual presentation of intestinal obstruction. *J Coll Physicians Surg Pak* 2009;19:582–3.