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Case Report

Recurrent Inguinal Hernia as Richter's Hernia

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Abstract

Richter's hernia is relatively rare type of incarcerated hernia, in which a wall of the bowel alone is entrapped within a hernia sac, maintaining the bowel continuity. The clinical diagnosis of a Richter's hernia is difficult, and a high index of suspicion is required to make a diagnosis. An early operative intervention is essential for preventing life threatening complications. We present a Richter's hernia in a recurrent inguinal hernia, which is extremely rare and only a few cases are reported in the literature [1].

Keywords: Hernia; Richter's; Recurrent; Inguinal

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Case Report

An obese elderly gentleman of 85years presented with abdominal distension, vomiting and constipation of 2days duration. He was suffering from Parkinson's disease and was disoriented. He had undergone surgery for left inguinal hernia about 40years ago, without a mesh. Examination revealed distension of abdomen with occasional bowel sounds. The groins and genitalia were normal. Since rectal examination revealed hard fecal matter, a clinical diagnosis of fecal impaction was made. Plain x ray and ultrasound revealed obstructed and dilated bowel. CT without contrast revealed a part of the sigmoid colon closely adherent to the inguinal region at the previous operation site. The patient was operated on emergent basis, through an inguinal incision, with the diagnosis of obstructed inguinal hernia. During surgery, in the hernia sac, the wall of the sigmoid colon was found to be incarcerated through the hernia defect (Figure 1), and the entrapped bowel wall was showing a dusky color. The ring was incised laterally, and the color of the bowel restored to normal slowly. The bowel was extracted further and found to be normal and viable and was returned into the abdominal cavity. The defect was closed with a polypropylene mesh to complete the repair. The patient had an uneventful recovery.

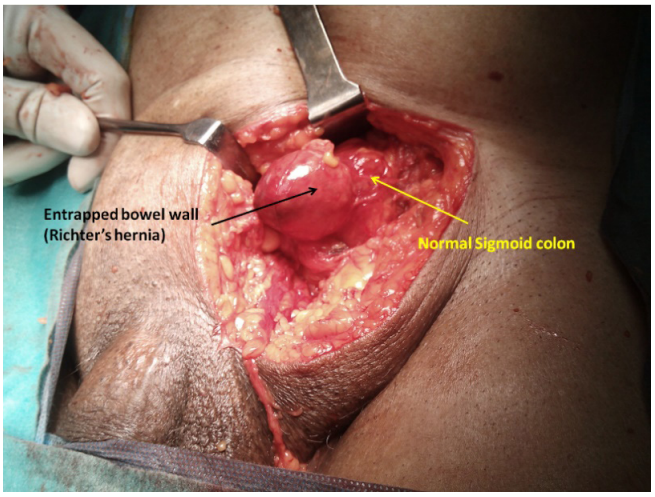

Figure 1: Operative photograph of Richter's hernia.

Discussion

Richter's hernia a rare type of incarcerated hernia in which a wall of the bowel is entrapped in the hernia sac. The first scientific description of this hernia was described by

Augustus Gottlob Richter in 1778 in a treatise on hernia, and the name Richter's hernia was given by Treves. The earliest report of a Richter's hernia was published by Fabricus Hildanus in 1598 [2]. Richter's hernia is commonly seen in women between 60 and 80years of age and comprise about 5-15% of all incarcerated hernias [3]. This can occur in children [4].

In 1956, Gillespie classified Richter's hernia patients into three groups according to the clinical presentation. The first group wall was called 'obstructive group' characterized by nausea, vomiting, peritonitis and constipation and threatened life if left untreated. The second group was called the 'post necrotic group' which was characterized by local strangulation with necrosis and perforation leading to enterocutaneous fistula. The third group was called 'dangerous group' which included minimal abdominal signs, but it caused delay in diagnosis increasing the morbidity and mortality [2]. Steinke et al. [5] added the fourth group, the 'unlucky perforation' group, in which the post necrotic abscess, as a result of unlucky anatomical constellations, accidentally find its way into another compartment, resulting either in a large abscess with severe septic/toxic load or in peritonitis; both of these would lead to a high death rate.

In Richter's hernia, only a wall of the bowel, usually the antimesenteric border is entrapped in the hernial ring, and that part of the wall becomes the content of the hernia. Any part of the bowel may get entrapped in this hernia, but commonly the ileum, cecum and the sigmoid. The incarcerated segment is usually small, and the intestinal continuity is preserved with partial intestinal obstruction with minimal signs [3]. This can occur in various locations, the commonest being the femoral region, followed by the inguinal canal and the abdominal wall incisional hernia [6]. Cases of Richter's hernia have been reported at laparoscopic port sites [7].

Clinical diagnosis of Richter's hernia is difficult due to innocuous signs and symptoms. The usual presenting symptom is pain or discomfort at the hernia site. The incarcerated segment of the bowel may get gangrenous and perforate [8]. The treatment of Richter's hernia is emergency surgery and the preferred approach is through the preperitoneal space to prevent inadvertent reduction which interferes with the examination of the affected bowel. Classical repair is done. If it reduces during anesthesia spontaneously, or the bowel viability is questionable, midline laparotomy is required to exclude the possibility of necrosis. If the bowel is found unviable, it is resected, and the hernia defect should be repaired.

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