

than males and right side more common than left side. They are mostly incarcerated at the time of presentation³. They account for 0.12% of spontaneous anterior abdominal wall hernias⁴.

The diagnosis of Spigelian Hernia depends to a great extent on awareness of its possible occurrence. The history of pain and the finding of a tender lump, adjacent to the rectus border should lead to a diagnosis³. Usually it is misdiagnosed as acute appendicitis, periappendicular abscess, cholecystitis, tumors of colon and kidney, subcutaneous hematoma of rectus sheath. Unless examined in both the standing and supine position the diagnosis may be missed.

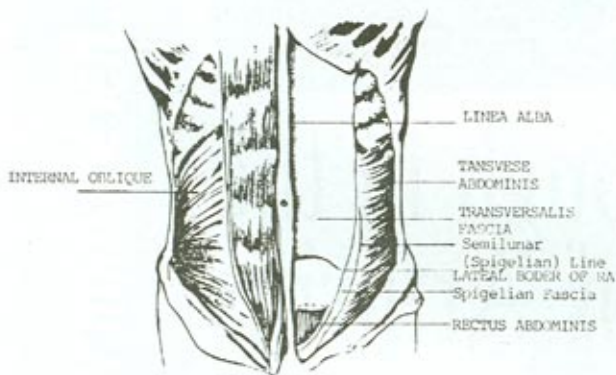


Figure 1. Ventral view of abdominal wall showing topographic anatomy. External oblique muscle and ventral of rectus sheath are cut away (right). Internal oblique and ectus abdominis muscle are removed (left). (RA = RECTUS ABDOMINIS).

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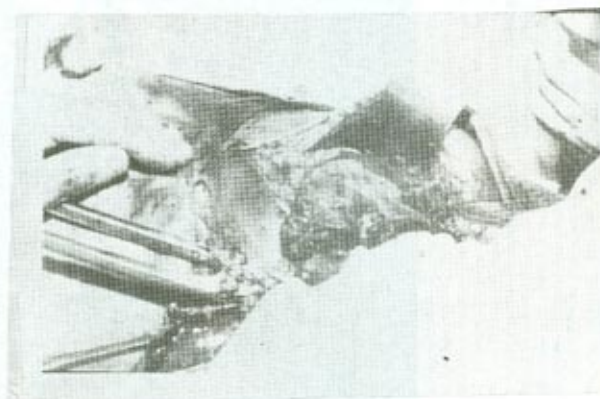


Fig. 2. Showing Gangrene of rectus muscle.



Fig. 3. Showing Gangrenous Loop of Jejunum

COMPLICATED SPIGELIAN HERNIA

NAHEED SULTAN

Introduction

Spigelian Hernia is defined as protrusion of a viscus, part of a viscus or preperitoneal fat through a congenital or acquired defect in the spigelian fascia. Spigelian Fascia is the part of the aponeurosis that lies between the semilunar line and the lateral rectus muscle⁽¹⁾. A spigelian hernia can occur theoretically anywhere along the spigelian line but vast majority occur at or near the semicircular line of Douglas, and it is rare in the most cranial part of abdomen (Fig. 1). Only about 800 cases are reported in literature⁽²⁾. The diagnosis is often overlooked because of the frequent lack of definitive physical findings, but must be considered in any case of lower, lateral, abdominal pain or tumor mass⁽²⁾.

Key Words: Hernia, Spigelian.

Case Report

A 40 years old female was admitted in emergency in Surgical Unit-IV of Civil Hospital Karachi, with complaints of painful swelling in the right hypochondrium. The swelling had been present for the last 7 years, which in the last three months had increased in size and had become painful in 3 days. Pain was continuous in nature and did not migrate. Pain was accompanied with vomiting and low grade fever. Vomitus was green in colour. Patient was 4 months pregnant.

On examination she was found to be anaemic and dehydrated. Her pulse was 100/min., temperature 101 degrees F, B.P. was 104/80 mm. Hg. There was a mass in the right hypochondrium

just below the costal margin. It was 5 x 4 cms. in size, red and tender, fixed to the muscles and fluctuation was not present. A diagnosis of abdominal wall abscess was made. Initial investigations showed WBC Count of 15,000/cu. mm. and Hb. of 8.0 gm/100 ml.

Next day patient started running high fever upto 103 degrees F, and was having persistent vomiting and had developed absolute constipation. Mass increased in size and fluctuation became apparent. Gut sounds were audible. Later on she developed abdominal distention. The diagnosis was then changed to strangulated Spigelian Hernia.

Operative Findings

Patient was operated in emergency and abdomen was opened by right paramedian incision. Hernial sac containing a loop of jejunum was seen to be entering the hernial orifice at the lateral margin of rectus abdominis muscle. The sac along with its contents was reduced. Jejunum was found to be gangrenous on its anti-mesenteric border. Resection and end-to-end anastomosis was done (Fig 2 & 3). Defects in the transversus abdominis and internal oblique muscle was repaired. External oblique and its overlying skin were quite necrotic and were left open. Later on secondary suturing was performed after a months time. Patient continued with her pregnancy and delivered a normal baby at full term.

Discussion

Literature contains references of 744 patients operated upon for Spigelian Hernia since its original description by Klinkosh in 1764.⁽²⁾ Age of onset varies widely but occurs mostly in 4th, 5th and 6th decades. Females are affected slightly more

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