

## **Case Report**

### **Perforated Incisional Richter's Hernia through a very old Tubectomy scar A Case Report**

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**Abstract:** Richter's hernia is the protrusion or strangulation of a part of the circumference of the intestine's antimesenteric border and most common sites are the femoral ring, inguinal ring. The commonest entrapped part of the bowel is the distal ileum, but any part of the intestine may be involved. These hernias rapidly progress to gangrene as compared to other hernias, and obstruction is infrequent. We present a rare case of Richter's hernia through an old incision in a lady operated for tubectomy thirty seven years back.

**Keywords:** Richter's hernia, obstructed hernia, Laparoscopic port.

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#### **INTRODUCTION**

Richter's hernia is the protrusion or strangulation of a part of the circumference of the intestine's antimesenteric border through a small defect in the abdominal wall [1]. The first case was reported in 1606 by Fabricius Hildanus and the first definition of partial enterocele was given by August Gottlieb Richter in 1785. They constitute 10 percent of strangulated hernias. Incisional hernias are usually caused by a weakness of the surgical wounds as a result of haematoma, seroma, or infection, that results in poor wound healing. Incisional hernia through tubectomy scar itself is a rare entity as the scar is very small but is equally dangerous as the opening is small and a high potential for strangulation. Richter's hernia through tubectomy incision i.e. Incisional Richter's Hernia is a new entity we found in an old aged lady long after she had undergone tubectomy. Usually incisional hernias have a wide ring and hence rarely land up in life threatening complications.

#### **CASE REPORT**

A 70 year old obese female came to the outpatient department with complaints of chronic pain in abdomen since two months which was slightly increased since eight days. There was no history of swelling over abdomen, abdominal

distention, vomiting and constipation. But patient had an history of fever four days back which was intermittent and persisted for two days and relieved with medications.

Patient had undergone tubectomy thirty seven years back. When patient was examined she was a febrile with all vital parameters within normal limits. On inspection the patient was obese and there was no obvious swelling seen over abdomen but on palpation there was a single diffuse fullness in the lower abdomen in the midline at the site of tubectomy scar ( Figure 1).

Swelling was tender but overlying skin was normal. Ultrasonography was done on the day of admission and was reported as lipoma and hence patient was treated conservatively. The patient's complaints were not relieved so a contrast enhanced tomography (CECT) was done which was reported as incisional hernia. The patient was posted for emergency exploration. It showed part of the ileal wall herniating through the scar with gangrene and perforation. A resection of the gangrenous segment was done and incision closed in anatomical layers. The patient was discharged on the tenth post operative day.



**Fig-1: Surface marking of the hernia on palpation**

## DISCUSSION

Any abdominal hernia in which 2/3 circumference of the bowel is entrapped is called as Richter's hernia. Diagnosis of Richter's hernia is confusing and difficult as it is based on high degree of clinical suspicion and is many a times diagnosed only on surgical exploration of the patient. As there is no complete obstruction of the bowel the patient may not present as a classical intestinal obstruction, but strangulation of the bowel needs urgent intervention. If there is any doubt in diagnosis a thorough investigation should be done including CECT of the abdomen [4]. As some times fewer investigations at initial presentation may lead to wrong diagnosis of patient, as in this case. Involvement of a partial wall of the bowel along with an obese abdomen masked the underlying complication.

During exploration of the abdomen if the involved bowel circumference is less than half the circumference of the bowel wall and not extending to the mesenteric border then Horbach recommends an invagination procedure without opening the intestine, i.e. Gangrenous area is invaginated and margins are sutured together [5]. If gangrenous part of bowel circumference is more than half the circumference resection of gangrenous segment and anastomosis is required which was done in this case.

After dealing with hernia contents, closure of the hernia orifice should be done to complete the total treatment of patient. Mesh repair is done only if bowel is not perforated. Recent studies prove that Richter's hernia is more common at port insertion sites in Laparoscopic surgery [6,7].

## CONCLUSION

As diagnosis of Richter's hernia is based on high clinical suspicion and is only confirmed on surgical exploration, mortality in such patients is reduced by early diagnosis and early surgical intervention.

## REFERENCES

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