Answer

Spigelian Hernia

Spigelian hernias constitute 0.1% to 0.2% of all abdominal wall hernias. Twenty percent are complicated by strangulation.[1] Spigelian hernias account for 2% of cases undergoing emergency surgery for abdominal wall hernia. However, it is rarely considered in the differential diagnosis for abdominal pain. We report a case of a giant spigelian hernia with bowel strangulation requiring bowel resection and abdominal wall repair with Surgisis mesh (Cook Medical, Inc, Bloomington, Ind).

Spigelian hernias can occur anywhere along the semilunar line, which runs parallel with the lateral edges of the rectus sheath. However, spigelian hernias most commonly occur at the level of the arcuate line. The arcuate line defines the point at which the posterior lamina of the internal oblique muscle and the aponeurosis of the transverse abdominal muscle become part of the anterior rectus sheath, leaving only the relatively thin transversalis fascia to cover the rectus abdominis posteriorly.[2] Spigelian hernias are described both in children and adults. Most cases are reported in adults between the ages of 40 and 70 years. They tend to be more common in women than men. Obesity, ascites, trauma, previous surgery, and increased intra-abdominal pressure are factors that contribute to the development of hernia.

Most of the spigelian hernias are intramural. The hernia usually enters the transverse and internal oblique muscles and is covered by the external oblique aponeurosis. Most patients present with nonspecific abdominal symptoms because the external oblique aponeurosis covers their hernias. They usually reveal a painful palpable mass on examination. Specific symptoms and findings may vary depending on the hernia contents. Omentum, gallbladder, stomach, small intestine, colon, Meckel diverticulum, appendix, ovaries, and testes have all been known to herniate.[3]

In addition to physical examination, ultrasonography and computed tomography are used for the identification of spigelian hernias. In fact, only 20% of all cases are correctly diagnosed preoperatively. Treatment is surgical. Repair has historically been performed via an open approach with primary approximation of tissues. Larger-sized hernias have used mesh. In 1992, Carter and Mizes[4] performed the first documented intra-abdominal laparoscopic spigelian hernia repair. Currently, the extraperitoneal laparoscopic approach is recommended for elective repair of noncomplicated spigelian hernias.[5] In our case, the presence of a large-sized spigelian hernia of 5×5 cm with bowel strangulation and perforation necessitated an open repair with Surgisis mesh as seen in Figure 2.

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