Answer

Incarcerated Paracecal Hernia

As we approached the end of the small bowel, we encountered a loop of terminal ileum incarcerated in a defect in the cecal mesentery. Gentle traction was applied with atraumatic forceps, which successfully released the incarcerated bowel. The mesentery around the defect was opened widely, thereby obliterating the natural orifice. The terminal ileum was then closely inspected and found to be viable. The patient tolerated the procedure. His postoperative course was uncomplicated, aside from a postoperative ileus that delayed the advancement of his diet. He was discharged on postoperative day 6 feeling well and tolerating a regular diet.

An internal hernia is defined as protrusion of a viscus through a peritoneal or mesenteric aperture. They are a rare cause of intestinal obstruction that make up fewer than 6% of all cases.[1,2] The aperture involved may be congenital, acquired secondary to surgery or trauma, or a preexisting anatomic structure such as the foramen of Winslow.[3] Naturally occurring internal hernias can be divided into 6 basic categories: transmesenteric, paraduodenal, transomental, paracecal, intersigmoid, paravesical/pelvic, and hernias through the foramen of Winslow.[4] Paracecal hernias are responsible for only 1.0% to 6.6% of internal hernias.[5,6] The anatomy of the cecal and paracecal peritoneum is the end result of ileocecal migration that occurs during rotation of the midgut in the fifth month of gestation. At that stage, 4 distinct peritoneal recesses of various depths occur in the paracecal area, namely the superior and inferior ileocecal recess, retrocecal recess, and paracolic sulci, all of which may become hernial orificies.[7,8]

Internal hernias are very difficult to diagnose preoperatively owing to the lack of specific signs and symptoms or characteristic findings on plain films or computed tomographic scans. In our case, computed tomography was able to confirm our suspicion of small-bowel obstruction but could not clearly identify the etiology. Definitive diagnosis usually requires direct visualization of the hernia either by diagnostic laparoscopy or open surgery. As surgeons become increasingly comfortable with more advanced laparoscopic techniques, more of these cases will be able to be definitively treated laparoscopically as well. Nevertheless, whether the approach be open or laparoscopic, this case serves to reinforce the dictum that small bowel obstruction in a patient with a "virgin abdomen" is a surgical disease and requires early operative intervention.

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