CASE REPORT

'Little old lady's hernia' causing small bowel obstruction in a man: a case report with a review of literature on the pathophysiology of obturator hernias

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SUMMARY

Commonly known as 'little old lady's hernia', obturator hernias are usually seen in frail, octogenarian multiparous women reporting non-specific nausea and vomiting, abdominal pain and anteromedial thigh pain. They are exceedingly rare; even less frequently are they diagnosed preoperatively, with the vast majority being found incidentally at laparotomy for small bowel obstruction. This case report describes an atypical presentation of a 'little old lady's hernia' in a man, in whom, thanks to high degree of clinical suspicion, an incarcerated obturator hernia was diagnosed preoperatively and treated successfully.

BACKGROUND

Obturator hernias are exceedingly rare, constituting 0.073% of all hernias in the West and 1% in the Far East¹; they are potentially the most lethal of all abdominal wall hernias, notoriously difficult to diagnose in the absence of specific symptoms and signs, and when diagnosed late, frequently necessitating small bowel (SB) resection. High degree of suspicion is thus necessary to allow prompt preoperative diagnosis of an obturator hernia, appropriate planning of surgical intervention and optimising the outcome.

CASE PRESENTATION

A 69-year-old cachectic man, with a history of left femoral hernia repair 18 months previously, presented to our surgical department with a 6-day history of vomiting, absolute constipation and anorexia.

INVESTIGATIONS

Chest and abdominal X-rays were non-diagnostic on admission. However, CT of the abdomen and pelvis performed the next day showed gross SB dilation with a transition point caused by a loop of SB herniating through the left obturator foramen (figure 1), and multiple loops of collapsed SB distal to this within the pelvis.

TREATMENT

Incarcerated left obturator hernia was diagnosed and an emergency exploration of the left groin (via lower midline laparotomy) was arranged. On inspection, the obturator hernia contained a dusky looking loop of SB, which was promptly resected,

and a side-to-side (functional end-to-end) anastomosis was done over the stapled line, with a subsequent closure of the hernia defect with prolene mesh.

DISCUSSION

Obturator hernias are exceedingly rare, constituting 0.073% of all hernias in the West and 1% in the Far East¹; even less frequently are they diagnosed preoperatively, with the vast majority being found incidentally at laparotomy for SB obstruction.²

They occur when the intestine protrudes through a defect in the obturator foramen and into the obturator canal, giving rise to a combined clinical picture of bowel obstruction with nausea, vomiting, abdominal pain, distension and weight loss,^{3 4} and in 15–50% of cases, anteromedial thigh pain (Howship-Rhomberg sign), caused by compression and irritation of the obturator nerve within the canal.⁵

Loss of the protective pre-peritoneal adipose tissue in the obturator canal, as often found in malnutrition, cachexia, chronic illness and advancing age, along with anatomical predisposition (wide pelvic bones, more horizontally oriented obturator canals and lax pelvic tissues), all predispose to formation of obturator hernias, which are therefore most commonly seen in frail, octogenarian multiparous women.⁶

This case report shows that 'little old lady's hernia'⁷ can present atypically in 'little men' in whom malnutrition and chronic illness may contribute to the weakening of the tissues around the obturator foramen and formation of a hernia.

They are potentially the most lethal of all abdominal wall hernias,⁸ notoriously difficult to diagnose in the absence of specific symptoms and signs, and when diagnosed late, frequently necessitating SB resection. Our case report thus highlights the value of a CT scan in establishing a prompt preoperative diagnosis of an obturator hernia, appropriate planning of surgical intervention, and thus optimising the outcome.

Lower midline laparotomy is the favoured surgical approach (others including abdominal, inguinal, retropubic, obturator and laparoscopic), providing excellent views of the obturator canal anatomy, and facilitating potential resection of the incarcerated and/or ischaemic bowel segment, reportedly needed in up to 80% of cases.¹ Currently, it is accepted that immediate closure of the hernia defect is essential; prolene mesh was used in this

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Figure 1 Loop of small bowel herniating through the left obturator foramen.

case for its inert, strong, thin and non-absorbable characteristics and capability of withstanding infection.

Adequate repair of the obturator hernia, minimal SB resection, and quick recovery with no postoperative complications is the goal of treatment, and was achieved in the case of our patient, who was discharged on day 6 postoperatively with no surgical follow-up.

Learning points

- ▶ 'Little old lady's hernia' can present atypically in 'little men' in whom malnutrition and chronic illness may contribute to the weakening of the tissues around the obturator foramen and formation of a hernia.
- ▶ High degree of suspicion is essential in the absence of specific symptoms and signs.
- ▶ CT scan is an invaluable tool in establishing a prompt preoperative diagnosis of an obturator hernia, appropriate planning of surgical intervention, and thus optimising the outcome.

Competing interests None.

Patient consent Obtained.

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