Clinicoradiological Images of a Rare Type of Lumbar Hernia

Arjun Agarwal^{1,2} · Sujoy Mukherjee¹ · Cheena Garg³

Received: 12 May 2015 / Accepted: 26 August 2015 / Published online: 4 September 2015
© Association of Surgeons of India 2015

Abstract A surgeon will rarely see a case of lumbar hernia in his lifetime. They are usually divided into superior and inferior types, but in cases of huge hernias where anatomical delineation is not possible, they are called as diffuse. Further classification into primary and secondary types (on the basis of etiology) and congenital and acquired types is done. Evisceration in a lumbar hernia can be present due to secondary causes but never spontaneously. This is therefore probably the first reported case of a primary eviscerated diffuse lumbar hernia.

Keywords Lumbar hernia · Diffuse · Eviscerated · Mesh repair

Background

P. Barbette in 1672 reported the first case of lumbar hernia although it was only in 1731 when the first case was published by R.J.C. Garangeot. Only about 300 cases have been

reported since then [1]. The lumbar region is bordered superiorly by the 12th rib, inferiorly by the iliac crest, medially by the erector spinae muscles, and laterally by the external oblique muscle. Lumbar hernias occur through two potential weak spaces, which are the superior and inferior lumbar spaces. A lumbar hernia is called diffuse when, due to a large hernia, an anatomical differentiation into superior and inferior triangles is not possible [2]. They can be congenital or acquired. Acquired hernias can be primary/spontaneous and secondary. Secondary lumbar hernias can occur due to trauma infections or following surgical interventions. Primary spontaneous hernias are the rarest among all the presentations.

Case Summary

A 50-year-old male presented with complaints of a lump on his right lower back for 2 years. On examination, there was a 28×18×12-cm swelling on his right lumbar region that was soft and with a positive cough impulse. There was a 1-cm by 3-cm defect on the swelling with prolapsed omentum (Fig. 1a) and a part of the ileum that reduced when the patient was made supine. A clinical diagnosis of eviscerated primary lumbar hernia was made which was confirmed by contrast CT scan (Fig. 1b,c). During surgery, the defect was bounded superiorly by the 12th rib, medially by the latissimus dorsi, laterally by the external oblique muscle, and inferiorly by the iliac crest (Fig. 1d). Diagnosis of diffuse lumbar hernia was made as the superior and inferior lumbar triangles were not clear. Incision was made over the hernia site, and contents were reduced. Defect was repaired using PROLENE no.1 in continuous fashion. Onlay repair of the defect with prosthetic mesh (polypropylene, 15×15 cm) was done. Mesh was sutured to the

✉ Arjun Agarwal
arjunbly@hotmail.com

¹ Department of General Surgery, Rohilkhand Medical College and Hospital, Bareilly, India

² Ashok Kiran hospital, C 8, Rampur Garden, Bareilly, Uttar Pradesh, India 243001

³ Department of Pathology, Rohilkhand Medical College and Hospital, Bareilly, India

Fig. 1 Diffuse eviscerated primary lumbar hernia

external oblique, latissimus dorsi, and the lumbar periosteum. This is probably the first reported case of a diffuse eviscerated primary lumbar hernia.

Conflict of Interest The authors declare that they have no competing interests.

References

1. Walgamage TB, Ramesh BS, Alsawafi Y (2015) Case report and review of lumbar hernia. *Int J Surg Case Rep* 6:230–232
2. Moreno-Egea A, Baena EG, Calle MC, Martínez JA, Albasini JL (2007) Controversies in the current management of lumbar hernias. *Arch Surg* 1:82–88