A strangled hernia through the Winslow's hiatus: about a rare situation

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ABSTRACT

Winslow's hiatus hernia is the rarest of the internal hernias. Its diagnosis is difficult and requires an urgent laparotomy to avoid necrosis of the incarcerated loop or even the death of the patient. We report the case of a patient operated urgently for acute intestinal obstruction caused by a strangled hernia through the Winslow's hiatus. A reduction by traction of the hernia was undertaken. Rapid management of this pathology is important using clinical and radiographical elements.

KEYWORDS

Strangled hernia – Winslow hernia – Acute abdomen – Emergency hernia

Accepted 14 January 2018

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Introduction

Internal hernias correspond to the outcome of intestine through a congenital or acquired intra-abdominal foramen. They represent 1% of all hernias.^{1,2} The Winslow's hiatus hernia, or Blandin's hernia, is the rarest of the internal hernias, accounting for 8% of cases.⁵ It is caused by the passage of intestinal loops in the omental bursa through the foramen of Winslow, which is a natural orifice of the abdominal cavity. It is difficult to identify and is diagnosed in less than 10% of cases preoperatively, leading to a high mortality of up to 49%.⁴ Treatment is based on urgent surgical reduction. We report the case of a patient operated urgently for acute intestinal obstruction caused by a strangled hernia through the Winslow's hiatus.

Case history

A 30-year-old patient with no previous medical history presented with diffuse abdominal pain, starting at the epigastrium, and vomiting. The patient was agitated, febrile at 38 degrees C and oliguric. The abdomen was distended with an epigastric guarding. Biology found leucocytosis 17000/mm³, C-reactive protein 170 mg/l and acute renal failure. Radiography of the abdomen (Fig 1) showed hydro-aerial levels with a level in the epigastric region, a gastric air pouch pushed up and left and the absence of pneumoperitoneum. The diagnosis of acute intestinal occlusion by strangulation with signs of severity was retained and the patient operated urgently after a short resuscitation.

A median laparotomy was performed. The exploration found a distended gut upstream of a loop incarcerated

behind the stomach, through a gaping Winslow's hiatus. Traction could not release it. We then proceeded to a coloepiploic detachment allowing access to the omental bursa (Fig 2). This assisted reduction of the loop, which had a good vitality. We did not perform any closure of the Winslow's hiatus. Outcomes were straightforward. We are currently 15 years postoperative and the patient has not experienced recurrence.

Discussion

Hernia of the Winslow hiatus, or Blandin's hernia, is the passage of the gut from the great peritoneal cavity to the omental bursa through a permeabilised Winslow's foramen. This situation is favoured by a gaping foramen, an abnormally long mesentery, a persistence of the right mesocolon or a misapposition of the right Toldt fascia.⁵ In the presence of an occlusive syndrome, some findings suggest a strangled hernia through the Winslow's foramen: the epigastric beginning of the pain,⁶ an epigastric arch and epigastric hydro-aerial level at the abdomen radiography.⁵ All these findings were present in our patient.

The diagnosis can be confirmed preoperatively by computed tomography showing the presence of intestines in the omental bursa with an anteroposterior widening of the Winslow's hiatus. Treatment is based on the urgent surgical reduction of the incarcerated loop, whose vitality will determine whether it is resected. A laparotomy is often necessary, the Winslow hiatus being difficult to access at laparoscopy. Visualisation of a stomach projected forward by an intestinal mass of the omental bursa passing behind the hepatic pedicle confirms the diagnosis.

Figure 1 Abdomen radiography: epigastric hydro-aeric level and gastric air pouch pushed to the left

A simple traction often releases the incarcerated loop. If not, some tips can help the release: finger dilatation and debridement of the hiatus,⁷ a large duodenopancreatic detachment⁸ or an opening of the omental pouch by a coloepiploic detachment or a section of the gastrocolonic ligament.⁷ Often, postoperative appositions allow spontaneous closure of the Winslow hiatus, which helps to prevent recurrence.³ Closure of the foramen by suture exposes the patient to vascular wounds and postoperative thrombosis of the portal vein and is therefore not recommended.⁸ As our patient has experienced no recurrence, we recommend reducing the loop without closing the gap.

Figure 2 Omental bursa access after colo-epiploic detachment

Conclusion

The hernia of the Winslow's hiatus is a rare anatomical situation. Diagnosis is difficult and requires an urgent laparotomy to avoid the necrosis of the incarcerated loop or even the death of the patient. Our clinical case shows the value of rapid management of this pathology.

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