

Spontaneous Posterior Rectus Sheath Hernia

Abhiyanth S

Columbia University, USA, E-mail:

abhiyanths@yahoo.com

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Abstract:

Posterior musculus sheath herniation could be a terribly rare type of wall herniation and there are unit scarce of reports of this rupture within the literature up to now. This case report presents a spontaneous posterior musculus sheath rupture during a seventy-nine-year recent male with previous abdominal surgery for inflammation. His rupture was discovered incidentally throughout examination for his chief complaints of lower abdominal pain and symptom that were later diagnosed as enterobacteria connected stomach flu. An X-radiation scan of the abdomen and pelvis showed wall herniation with loops of little gut extending into the musculus abdominis muscle. during this case, it absolutely was set to go away the case alone for currently because of no proof of gut obstruction and also the low risk of this herniation obtaining strangulated, that otherwise would have bonded imperative surgery. This report adds to restricted stock of obtainable literatures on this distinctive issue and strengthens evidence-based on best approach to support knowing clinical deciding. Vital clinical implication of such case reports is enlarged identification rate of rare clinical conditions that otherwise usually go ignored.

Introduction: Hernias of the posterior rectus sheath are very rare abdominal wall hernias with only a handful of cases reported in the literature to date. As an uncommon disease, it is important to recognize and report this case in order to enhance scientific knowledge of this disease.

Case Report: This case report presents a spontaneous posterior muscle sheath rupture in an exceedingly 79-year-old Caucasian with previous abdominal surgery for inflammation. His rupture was discovered incidentally throughout associate degree examination for his chief complaints of lower abdominal pain and diarrhoea that were later diagnosed as Salmonella-related stomach flu. A computerized tomography scan of his abdomen and pelvis showed paries herniation with loops of tiny internal organ extending into his muscle abdominis muscle. During this case, it absolutely was determined to depart true alone for currently because of no proof of internal organ obstruction and therefore the low risk of this herniation obtaining strangulated, that otherwise would have guaranteed imperative surgery. On examination, general signs of poor health were ascertained. His pressure was 150/60 mmHg and vital sign ninety beats per minute (bpm). His temperature was thirty-seven.3°C and he did not seem to be in distress. A physical examination did not reveal any internal organ obstruction. His laboratory findings were among traditional vary aside from associate degree elevated

white vegetative cell count ($14.5 \times 10^9/L$), slightly low red vegetative cell count ($3.12 \times 10^{12}/L$), and slightly raised level of creatinine ($124 \mu\text{mol}/L$). His anamnesis enclosed recent completion of therapy treatment for a Gleason score nine prostate carcinoma, previous vas event, asbestosis, fibrillation, and chronic bodily fluid cancer of the blood. His abdominal surgical history enclosed solely associate degree open excision forty years previous. He's a retired naval engineer and lives together with his woman. He according that he didn't drink alcohol and had quit tobacco smoking thirty years past. His case history is noncontributory. Computerized tomography (CT) of his abdomen and pelvis was performed and incontestible a serous membrane recess containing multiple tiny internal organ loops over the anterior facet of the intraperitoneum lying between serous membrane lining and therefore the thwartwiseabdominis fascia per a pseudoherniation of a preperitoneal subtype. There was no mass or dilatation of internal organ loops and no mass to his higher abdominal organs seeable of CT abdomen findings, a surgical opinion was wanted. As there was no proof of internal organ compromise, he was managed non-operatively. Unclean enzyme chain reaction (PCR) tested positive for enterics and our patient improved on antibiotics with resolution of abdominal pain. He was discharged and followed up two weeks later at out-patient clinic and had no abdominal discomfort; so, no elective herniation repair was planned, and more follow-up wasn't indicated.

Discussion: Spontaneous posterior musculus sheath hernias were initial documented in 1937. they're extremely rare with a case series in 2009 distinguishing solely eight cases within the literature with 2 further cases according in 2014 and 2017 Among 3 differing types of intraparietal hernias, opening is that the commonest In our case, the herniation was preperitoneal because the herniation was placed between the serous membrane and transversalis connective tissue up to now, the pathophysiology of posterior musculus sheath herniation isn't well understood Examining the general anatomy of the wall, it's famed that the musculus sheath is created by interior oblique muscle, external oblique muscle, abdominal muscle, and membrane bone serous membrane. This provides robust resistance against spontaneous hernia. However, below the arced line, the posterior musculus sheath contains solely cross abdominis muscle that makes this structure weaker as compared to the anterior sheath. Biomechanical analysis showed posterior sheath elements of linea alba to be dilutant than the anterior elements which could be one attainable rationalization for internal structures invasive a weaker structure .additionally, it's been hypothesized that, kind of like different form of hernias, any conditions that increase intra-abdominal pressure like physiological condition, obesity, ascites, and progressive muscle weakness increase the probability of those hernias.