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Obturator Hernia: A Case Report

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ABSTRACT:
Obturator hernia is an extremely rare type of abdominal wall hernia occurring mostly in elderly, thin females.It occurs due herniation of intra-abdominal contents through the obturator foramen. Patient usually presents with the features of intestinal obstruction. Patient may complain of inner thigh pain that may extend to the knee on internal rotation of the hip due to the irritation of obturator nerve, known as Howship-Romberg sign. Computed tomography of the abdomen and pelvis are often necessary to arrive at a diagnosis. Immediate surgical intervention is recommended.
Objective: To know about this rare etiology so that one can keep it as a differential diagnosis for intestinal obstruction and thus manage accordingly.
Keywords: Obturator Hernia, Intestinal Obstruction, Thin females, Elder females, Lateral thigh pain.

I. INTRODUCTION:

Obturator hernia is a rare pelvic hernia with a relatively high morbidity and mortality. It was first described by Ronsil in 1724.[1] This is also known as little old lady's hernia due to atrophy and loss of the pre-peritoneal fat around the obturator vessels in the canal. The incidence rates of obturator hernia vary widely throughout the world. It accounts for 0.07%–1.0% of all hernias, and 0.2%–1.6% of all cases of mechanical obstruction of the small bowel.[2]Obturator hernia is difficult to diagnose as signs and symptoms are often nonspecific thus are potentially the most lethal of all abdominal wall hernias due to delay in diagnosis. Various imaging modalities have been applied to establish the diagnosis but the CT scan has superior sensitivity and accuracy.[3]

II. CASE PRESENTATION:

A 76-year-old female patient presented to the hospital with complaints of pain abdomen and vomiting from 4 days. Vitals were PR: 110/min BP-100/60 mmhg Spo2- 96% @ room air. On abdominal examination there was distension of the abdomen and bowel sounds were absent. Abdominal X-ray shows multiple air fluid levels. Patient was planned for CECT- Abdomen which shows herniation of distal ileum through the right obturator foramen with the herniated loop lying superficial to obturator muscles measuring 2.2*2.7*3 cm and shows normal wall enhancement. Jejunum and distal ileum were collapsed. On laparotomy, the intestine was seen herniating in the right obturator foramen. Content was reduced. There was defect of size around0.5*0.5 cm. Defect was closed with the prolene mesh. Post operative period was uneventful.


Fig. 1 Intestine loop herniation in obturator foramen


Fig. 2 Intestine loop herniating through obturator foramen

III. DISCUSSION:

The hernia protrudes through the obturator foramen situated bilaterally in the anterolateral pelvic wall, inferior to the acetabulum.[4]The obturator hernia is most commonly found in females.It accounts for about 1% of all abdominal hernias and possesses a great diagnostic challenge due to the non-specific symptoms and meagre clinical signs.[5] Obstruction is usually partial due to a high frequency (41%–100%) of Richter's herniation of the small bowel into the obturator

canal.[2] Several imaging modalities have been described to diagnose obturator hernia including plain radiographs of the abdomen, ultrasonography, and barium enema, but CT of the abdomen and pelvis is most relevant.The only treatment for obturator hernia is surgery.[6]Surgical repair with non-absorbable sutures is the mainstay of therapy performed with open or laparoscopic techniques. A mesh plug has been used in the uncontaminated field. Repair of a contralateral obturator canal defect is rarely attempted due to a low recurrence rate and the need for additional operative time.[7]

IV. CONCLUSION:

Elderly thin female patients presenting with features suggestive of small bowel obstruction and positive Howship-Romberg sign should always raise suspicion for an obturator hernia. A CT scan of the abdomen and pelvis can be very helpful, and early surgical management is the mainstay of treatment.

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