Epigastric hernia

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These hernias arise through the midline raphe (linea alba) anywhere between the xiphoid process and the umbilicus. They begin with a transverse split in the midline raphe so the defect is elliptical and usually less than 1 /uni00A0 cm in diameter. The hernia commonly contains only extraperitoneal fat, which gradually - enlarges, spreading in the subcutaneous plane to resemble the shape of a mushroom (Figure 64.21). When very large they may contain a peritoneal sac but rarely any bowel. More than - one hernia may be present. Indeed, the most common cause of ‘recurrence’ is failure to identify a second defect at the time of original repair. Clinical features The patients are often fit, healthy men, but they are also seen in older, overweight men and women especially after multiple pregnancies. The hernia can be very painful even when the swelling is small owing to the fatty contents becoming nipped su ffi ciently to produce partial strangulation. It may be locally tender. It is unlikely to be reducible because of the narrow neck and may resemble a lipoma. A cough impulse may or may not be felt. Treatment V ery small epigastric hernias have been known to disappear spontaneously , probably because of infarction of the fat. Small- to moderate-sized hernias without a peritoneal sac are not inherently dangerous and surgery should be o ff ered only if the hernia is su ffi ciently symptomatic. Hernias containing bowel should always be repaired. Surgery This may be open or laparoscopic. At open surgery , a vertical or transverse incision is made over the swelling and down to the linea alba. Protruding extraperitoneal fat can simply be pushed back through the defect or excised. Often a small vessel is present in the hernia content that can cause troublesome bleeding. Small defects in the linea alba may be closed with non-absorbable sutures in adults and absorbable sutures in children; however, in larger hernias and when a peritoneal sac is present, the surgical approach is similar to that described for an umbilical mesh repair. Laparoscopic repair is also very similar to that for umbilical hernia except that the defect is hidden behind the falciform ligament, which must first be taken down from the undersur face of the abdominal wall to allow the mar gins of the defect to be exposed. It is very important to fully reduce the fatty contents, as simply placing a mesh under the linea alba may leave the patient with a palpable lump if the hernia contents are extraperitoneal fat.

Figure 64.21 Epigastric hernia.

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