Rare external hernias

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Perineal hernia Primary perineal hernias are very rare. The majority of perineal hernias encountered are some form of incisional hernia arising after previous pelvic floor surgery or trauma. This type of hernia includes: Paul H Sugarbaker , contemporary , surgeon, Washington Cancer Institute, Washington, DC, USA.). Only - /uni25CF postoperative hernia through a perineal scar, typically after excision of the rectum; /uni25CF median sliding perineal hernia, which is a complete pro - lapse of the rectum; /uni25CF anterolateral perineal hernia, which occurs in women and presents as a swelling of the labium majus; /uni25CF posterolateral perineal hernia, which passes through the levator ani to enter the ischiorectal fossa. A combined abdominoperineal operation is generally employed. The hernia is exposed by an incision directly over it. The sac is opened and its contents ar e reduced. The sac is cleared from surrounding structures and the wound closed. With the patient in semi-Trendelenburg position, either lap - aroscopically or at open surgery , the abdomen is opened and the mouth of the sac exposed. The sac is inverted, ligated and excised, and the pelvic floor repaired by muscle apposition and, if indicated, buttr essing of the repair with prosthetic mesh or tissue flap with the involvement of plastic surgeons. Obturator hernia Obturator hernia, which passes through the obturator canal, occurs six times more frequently in women than in men. Most patients are older than 60 years. Any swelling is liable to be overlooked because it is covered by pectineus. It seldom causes a palpable lump but, if the limb is flexed, abducted and rotated outwards, the hernia sometimes becomes apparent. The leg is usually kept in a semiflexed position and movement increases the pain. In more than 50% of cases of strangulated obturator hernia, pain is referred along the obturator nerve by its genic - ulate branch to the knee. On vaginal or rectal examination the hernia can sometimes be felt as a tender swelling in the region of the obturator foramen. These hernias are most frequently diagnosed on a CT scan, usually requested to investigate pelvic pain or bowel

Figure 64.27 Abdominal computed tomography scan showing mesh bulge (pseudo-recurrence) 2 years after a laparoscopic repair of inci

sional hernia. The two white dots are metal tacks still in place, /f_i xing the mesh to the underside of the abdominal wall.

presentation. Occasionally , asymptomatic obturator hernia defects are noted at laparoscopy on the lateral pelvic wall, under the pubic arch. Surgery is indicated. The diagnosis is rarely made preoperatively and so it is often approached through a laparotomy incision. The full Trendelenburg position is adopted. The constricting agent is the obturator fascia, which can be stretched by inserting the operator’s index finger, or suitable forceps, through the gap in the fascia. The content is reduced. If incision of the fascia is required, it is made parallel to the obturator vessels and nerve. The contents of the sac are dealt with in a standard manner. The defect cannot simply be closed because one margin is bone and the obturator nerve and vessels run through it. It is best repaired using a flat mesh laid over the defect in the extraperitoneal plane. In the absence of mesh or in an infected field, the broad ligament can be sutured over the defect or used as a plug. Laparoscopic TAPP repair may also be performed again using a mesh. As with other extraperitoneal mesh repairs, mesh fixation is often not required. Alternatively , to avoid nerve injury , tissue g lue can be used to fix a mesh over the defect. Note that it can be very di ffi cult to reduce an incarcerated hernia lap aroscopically and it is easy to damage the bowel with traction. Gluteal and sciatic hernias Both of these hernias are very rare. A gluteal hernia passes through the greater sciatic foramen, either above or below piriformis. A sciatic hernia passes through the lesser sciatic foramen. Di ff erential diagnosis must be made between these conditions and: /uni25CF a lipoma or other soft-tissue tumour beneath gluteus max imus; /uni25CF a tuberculous abscess; /uni25CF a gluteal aneurysm. All doubtful swellings in this situation can be characterised with CT scanning but, if in doubt, they should be explored by operation. After reduction of the hernia contents, complete closure of the defect may not be possible because of the unyielding bony and ligamentous margins of the hernia orifices. Bridging mesh may be useful but should not be placed directly on top of major nerves or vessels in the vicinity for fear of causing local irritation and neuralgic pain.

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