Introduction

A postoperative ventral abdominal wall hernia, more commonly termed incisional hernia, is escape of organs from their physiologic position through an area of weakness in the surgical scar. It results as a failure of fascial tissues to heal and close following laparotomy. These hernias can increase in size to enormous proportions, and giant ventral hernias can contain a significant amount of small or large bowel. Incisional hernias have been reported in up to 20% of patients undergoing laparotomy [1-3]. The incidence of incisional hernia following Caesarean section by vertical incision is 3.1%. Spontaneous rupture of abdominal hernia is very rare and usually occurs in incisional and recurrent groin hernias. Conservative management such as manual reduction and use of abdominal binder until term has been applied with unreliable success. Additionally, surgical intervention such as antepartum hernial repair has also been undertaken in few women while allowing for normal vaginal delivery at term. The rarity of this condition prompted us to report a case of spontaneous rupture of incisional hernia in a 35 years old pregnant lady who had developed incisional hernia following caesarean section.

Keywords: incisional hernia, concealed pregnancy, caesarean section, normal delivery, mesh repair

Presentation of the Case

A female patient, 35 years old, presented to the trauma and emergency section of Jawaharlal Nehru Medical College and hospital with abdominal pain and evi- dence of spontaneous rupture of incisional hernia following caesarean section. Presentation of spontaneous rupture of incisional hernia in a 35 years old pregnant lady who had developed incisional hernia following caesarean section.

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about 6 by 6 cm. massive peritoneal adhesions with healthy bowel (Fig-2). Lower segment hysterotomy was done delivering a live 1500 gm male baby (Fig-3). Uterus was closed after the removal of placenta and hemostasis was achieved. The hernial sac was dissected. The rectus sheath was mobilised and repaired with Prolene no-1 RB followed by onlay polypropylene mesh repair (Fig-4). Excess lax, necrosed and thinned out skin was trimmed and the wound was closed with a suction drain. The drain was removed on 8th postoperative day. Recovery was uneventful and the patient was discharged on the 9th postoperative day with a contraceptive advice of IUCD placement. The baby could not survive and died 2 weeks after surgery. The patient is still on follow up and is doing well.

Discussion
In pregnancy, ventral hernias are very difficult to understand because of its rare occurrence and becomes serious obstetric problem if complications such as incarceration, strangulation or spontaneous rupture occur [7, 8]. Incisional hernia following Caesarean section has been associated with wound infection, malnutrition and poor surgical technique. Other associated factors include additional operative procedure, presence of postoperative abdominal distension, intra-abdominal sepsis, residual intra-abdominal abscess, wound dehiscence and postoperative fever [4]. Conservative management such as manual reduction and use of abdominal binder until term has been applied with unreliable success [8]. Additionally, surgical intervention such as antepartum hernial repair has also been undertaken in few women while allowing for normal vaginal delivery at term [8]. Some studies recommend postponing herniorrhaphy until post-partum because the enlarged uterus itself and laxity of the abdominal wall may hinder optimal repair and enlargement with advancing gestation may further disrupt the repair. On the contrary, few other authorities have recommended that herniorrhaphy can be performed during pregnancy if there is evidence of gross incarceration, strangulation or skin necrosis [7, 8]. With the tension-free mesh technique the recurrence rates for hernias compared to tissue repairs has drastically reduced. Thus, in our case, herniorrhaphy with tension-free mesh placement has been successfully performed as part of the caesarean section with no incidence of wound infection and recurrence.

Figure-Eviscerated bowel loops and delivery of a live baby along with onlay mesh repair

Conclusion
There is a dilemma in the management of incisional hernia in pregnancy because no evidence-based approach has been
described in the literature. Conservative management with manual reduction and use of abdominal binder has been used with some success. Surgery is the definitive management for large incisional hernias and for those impending rupture and is judiciously used in pregnancy.

Conflict of interest
The authors declare that there are no conflicts of interests regarding the publication of this article.

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References