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Richter-type of spigelian hernia: A rare case report

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Abstract
Spigelian hernia occurs through slit like defect in the anterior abdominal wall adjacent to the semilunar line. Most of spigelian hernias occur in the lower abdomen where the posterior sheath is deficient. The hernia ring is a well-defined defect in the transverses aponeurosis. The spigelian hernia is rare with an incidence range from 0.12% to 2% of all abdominal wall hernias. Spigelian hernia presenting as Richter-type with acute abdomen is very rare.

Keywords: Richter-type hernia, spigelian hernia

Introduction
Spigelian hernia is named after Adriaan van Spieghel, who depicted the semilunar line in 1645 [1]. The semilunar line represent the transition of the transversus abdominis muscle to its aponeurotic tendon [2]. Spigelian fascia is located between the semilunar line and the lateral edge of the rectus abdominis muscle. Spigelian hernia occurs through a defect in the spigelian fascia [3]. The spigelian hernia is rare with an incidence range from. 12% to 2% of all abdominal wall hernias [4, 5]. Spigelian hernia occurs anywhere on the Spigelian fascia, but it is reported that more than 90% of these hernias are located in the "Spigelian belt", which is a transverse 6-cm-wide zone in the lower abdominal wall. Patient often present with localized intermittent pain in the area without bulge. Ultrasound and CT of abdomen can aides in diagnoses [6, 7]. Once diagnosed, spigelian hernia should be repaired either by open or laparoscopic due to high risk of strangulation [4, 5].

Case summary
A 26 year old female was admitted to surgical ward with complain of pain right lower abdomen, nausea and episode of vomiting. On examination tenderness present over right lower abdomen. USG show 21*28mm blind end structure arising from distal ileum with gut signature s/o Meckel`s diverticulum. Blood investigation shows high WBC and left shift. Patient underwent emergency surgery through right paramedian incision. Intraoperative finding show a hernial defect of size 1.5*2 cm just lateral to rectus muscle containing a small portion of the antimesenteric wall of terminal ileum. Hernial content reduced and found inflamed but viable. Defect closed by suturing transverse abdominis to rectus muscle with polypropylene suture. Post-operative period was uneventful, patient discharge on post-operative day 5th in clinically satisfactory condition.

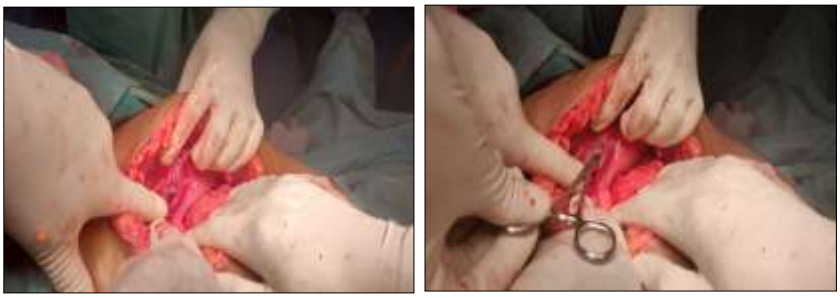

Fig 1: Intraoperative finding of spigelian hernial defect

Discussion

Richter-type Spigelian hernia is rare and has been reported infrequently in the existing literature [4, 5]. Clinical diagnosis is challenging [8, 9] and USG & CT scan aides the diagnosis [6, 7]. Surgical repair is the definitive treatment and involves primary or mesh repair of the defect as appropriate [4, 5].

Conclusion

A localized pain in area of spigelian fascia with nausea and multiple episode of vomiting may suggest atypical presentation of spigelian hernia which required high degree of suspicion and radiological investigation for correct diagnosis. Spigelian hernia has high risk of strangulation, so proper early diagnosis is needed to prevent dire outcome.

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