Abdominal Internal Hernias; 5 Cases At Aristide Le Dantec Hospital
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Introduction: Internal hernias correspond to an exit of bowel through a congenital or acquired intra-abdominal opening. In spite of their rarity, their anatomical and clinical characteristics are varied. They constitute a rare cause of digestive occlusion (approximately 1 to 5.8 % of all the occlusions). Materials and method: This is a retrospective study concerning 5 cases of internal hernias treated at Aristide Le Dantec hospital between October, 2004 and November, 2008. The studied parameters were: the circumstances of the diagnosis, the anatomical varieties, therapeutic care and results of the follow-up.

RESULTS
This study comprises 3 men and 2 women. The patients were 44 years, 60 years, 6 months, 82 years and 44 years old. The circumstance of discovery was always an acute intestinal obstruction. CT scan realized at 3 patients had not allowed suspecting the internal hernia even if it had confirmed the organic occlusion. In 2 cases, it showed a bowel striction (figures 1 and 2) and in the third case, it evoked intestinal intussusception.

Figure 1
Figure 1: CT scan of observation 1 showing dilated loops in the right iliac area corresponding to a right para-duodenal hernia.
Figure 2
Figure 2: CT scan of observation 2 which evokes an intussusception and corresponds to a supra-vesical hernia.

The diagnosis of internal hernia was always made per operating (after laparotomy). At exploration, 1 right para-duodenal hernia, 1 supra-vesical hernia, 1 trans-mesenteric hernia, 1 trans-mesocolic hernia and 1 broad-ligament hernia were found (figure 4).

Figure 3
Figure 4: Per-operative view of the hernia of the broad ligament showing the incarcerated bowel and the opening in the broad ligament after reduction.

In the cases 1, 2 and 3, aetiology was congenital (table I). In the third and fourth patient, the hernias were acquired; we noted a recent surgical history (colostomy for ano-rectal malformation) in one of them and multiparity in the other one (table I). The treatment consisted of reduction of viable bowel herniated and closure of the abnormal opening. Recovery was uneventfully in 4 patients. The 82-year-old patient died as a result of an ischemic gangrene of the leg treated by amputation.

Figure 4
Table I: Summary of the 5 observations.

<table>
<thead>
<tr>
<th>Patients</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Medical History</th>
<th>Hernial variety</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>44</td>
<td>M</td>
<td>Peritoneal tuberculosis</td>
<td>Right para-duodenal hernia</td>
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</tr>
<tr>
<td>2</td>
<td>50</td>
<td>M</td>
<td>—</td>
<td>Supra-vesical hernia</td>
<td>Simple</td>
</tr>
<tr>
<td>3</td>
<td>80</td>
<td>M</td>
<td>—</td>
<td>Trans-mesocolic hernia</td>
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<tr>
<td>4</td>
<td>5</td>
<td>F</td>
<td>Colostomy</td>
<td>Trans-mesenteric hernia</td>
<td>Simple</td>
</tr>
<tr>
<td>5</td>
<td>44</td>
<td>F</td>
<td>Multiparity</td>
<td>Broad-ligament hernia</td>
<td>Simple</td>
</tr>
</tbody>
</table>

DISCUSSION
Abdominal internal hernias are responsible for 1 to 5.8 % of intestinal obstructions [1]. They are rare and often underestimated with necropsic discoveries in the order of 0.2 to 2% [1]. The anatomical varieties are multiple with a majority of para-duodenal hernias [2,3]. Their origins are congenital or acquired. During the embryonic development, the necessity of rotation of the primitive bowel can come along with defects as the origin of dimples and of abnormal openings responsible for congenital internal hernias. In contrast, acquired causes (surgical or traumatic) lead to so-called acquired internal hernias. Three groups of internal hernias can be distinguished:

- Internal hernias through a natural opening (hiatus of Winslow);
- Hernias through an abnormal opening as in 3 of our observations with 1 trans-mesocolic, 1 trans-mesenteric and 1 hernia of the broad ligament;
- Retro-peritoneal hernias with 2 cases in our series: 1 para-duodenal and 1 para-vesical hernia.

The diagnosis of these internal hernias is difficult because of their non-specific symptoms. They often show themselves by an occlusive accident just like our 5 cases. A preoperative diagnosis is exceptional. Imaging can confirm the organic occlusion but is not always sure for the diagnosis of internal hernias. The scanning realized in 3 cases did not allow us to make the diagnosis of internal hernia. Yutaka [4] reported CT images of a hernia of the bottom of Douglas’ pouch. Chien-Heng [5] reported the first case of preoperative diagnosis of right para-duodenal hernia by scanning. The diagnosis is mostly made per operating [6]. The analysis (a posteriori) of the CT images can allow visualizing radiologic characteristics of internal hernias. Martin [1], Selcuk [7], Zissin [8] and Takeyama [9] described the radiological presentations of the main internal hernias. During the exploration of the abdominal cavity, the diagnosis of the anatomical variety is often not evident, as reported by Ménegaux [10]. Several landmarks such as duodenojejunal angle, cœcum, liver or splenic angle of the colon and rectosigmoid can help.

Some peculiarities are to be underlined in the therapeutic care of these internal hernias. The ablation of the hernial sac is banned, useless, impossible, and even dangerous [11]. The closure of the abnormal openings is made by stitches.
avoiding damaging the vessel which usually goes along these snares [11].

Some authors treated internal hernias successfully by laparoscopy [12, 13].

CONCLUSION

Even if their frequency is low, it is advisable to evoke internal hernias during an acute bowel occlusion, especially in the absence of a surgical history and of exteriorized hernias. For the surgeon operating, it is necessary to prevent them in particular by calibrating the transmesocolic passages of organs; by repositioning the colon after partial colectomy; and by closing mesocolic and mesenteric breaches after intestinal resection.

References

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