



REVIEW

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Acute intestinal obstruction secondary to left paraduodenal hernia: a case report and literature review

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Abstract

Introduction: An internal hernia is a protrusion of bowel through a normal or abnormal orifice in the peritoneum or mesentery. Although they are considered as a rare cause of intestinal obstruction, paraduodenal hernias are the most common type of congenital hernias.

Methods: A literature search using PubMed was performed to identify all published cases of left paraduodenal hernia (LPDH).

Results: In Literature search between 1980 and 2012 using PubMed revealed only 44 case reports before the present one. Median age was 47 years (range 18 – 82 years). Nearly 50% reported previous mild symptoms. Two-third of patients required emergency surgery in form of laparotomy or laparoscopic repair. Reduction of hernia contents with widening or suture repair of the hernia orifice were the most common standards in surgical management of LPDH.

Conclusion: Intestinal obstruction secondary to internal hernias is a rare presentation. High index of suspicion and preoperative imaging are essential to make an early diagnosis in order to improve outcome.

Introduction

Internal hernia is, either congenital or acquired, a rare cause of small-bowel obstruction, with a reported incidence of less than 2% [1]. Paraduodenal hernias, which are a type of internal hernia, occur due to malrotation of midgut and form a potential space near the ligament of Treitz [2]. Incidental finding at laparotomy or on imaging is the most common presentation of these hernias [3]. Nevertheless, Paraduodenal hernias can lead to bowel obstruction, ischemia, and perforation with a high mortality. Left paraduodenal hernia (LPDH) is the most common types of congenital hernias and accounts for more than 40% of all cases [4]. Clinical diagnosis of LPDH is a real challenge as symptoms are entirely non-specific. Therefore, a timely and correct diagnosis with a rapid diagnostic tool is mandatory [5]. In this review we

discuss the clinical presentation and management of small bowel obstruction secondary to LPDH.

Case presentation

A 47-year-old Caucasian male admitted with increasing severe colicky abdominal pain and bile stained vomiting of 2 days duration. He had no previous significant past medical or surgical history. He also denied any history of weight loss, or recent changes in his bowel habit. However, He described at least 4 previous episodes of upper abdominal distension and vomiting with spontaneous resolution over the previous 2 years. On examination, the patient appeared in moderate pain with normal vital signs. Abdominal examination revealed abdominal distension with a tender mass in the left upper quadrant. Laboratory studies were essentially normal. An urgent abdominal CT scan confirmed the diagnosis of small bowel obstruction secondary to what looked like a hernia into the left paraduodenal fossa (fossa of Landzert) (Figure 1). At laparotomy, a hernia sac of 25 cm in diameter arising from a defect just to the left of the fourth part of the duodenum was found, consistent with

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a LPDH (Figure 2A). The intestinal loops were herniated through that congenital defect and were not spontaneously reducible. A band containing the inferior mesenteric vein was deemed necessary to divide at the time in order to widen the orifice of the defect and to retrieve the dilated small bowel from the hernia sac (Figure 2B). The hernia sac was excised completely down to the base at the mesentery of large bowel (Figure 2C). The patient had uneventful postoperative recovery and discharged home 5

days later. At 8 weeks post-surgery, he was back to full normal activities with a well-healed laparotomy scar.

Discussion

Internal herniation of the small bowel is a relatively rare cause of intestinal obstruction and accounts for less than 2% of all causes [1]. Among all congenital hernias, paraduodenal hernias are the most common type with an overall incidence of approximately 50% of all internal hernias [1,4,6]. LPDH (hernia of Lanzert) is about three times more common than the right counterpart (Waldayer's hernia) [7]. LPDH arises from the fossa of Landzert, a congenital defect which presents in approximately 2% of the population, located to the left of the fourth part of the duodenum, posterior to the inferior mesenteric vein and left branches of the middle colic artery (Figure 2A) [2,8,9]. Small bowel loops (usually jejunum) prolapse posteroinferiorly through the fossa to the left of the fourth part of the duodenum into the left portion of the transverse mesocolon. Hence, the herniated small bowel loops may become trapped within this mesenteric sac (Figure 2C) [4,10].

Literature search between 1980 and 2012 using PubMed revealed only 44 case reports before the present one [2,5,11-49] (Table 1). Median age at presentation was 47 (range of 18–82 years old) with male to female ratio of 3:1. In this review, patients often presented with symptoms and signs of typical of internal hernias complicated by bowel obstruction, strangulation, and/or necrosis. Besides, 43% of patients reported a prior history of recurring abdominal pain with symptoms. Only three cases presented with a palpable mass in the left upper quadrant at time of presentation.

Radiological diagnosis of LPDH prior to surgery was achieved in 43% of patients. On CT scan, typical appearance of LPDH is an encapsulated sac containing clusters of dilated small bowel loops at or above the ligament of Treitz with a mass like effect compressing

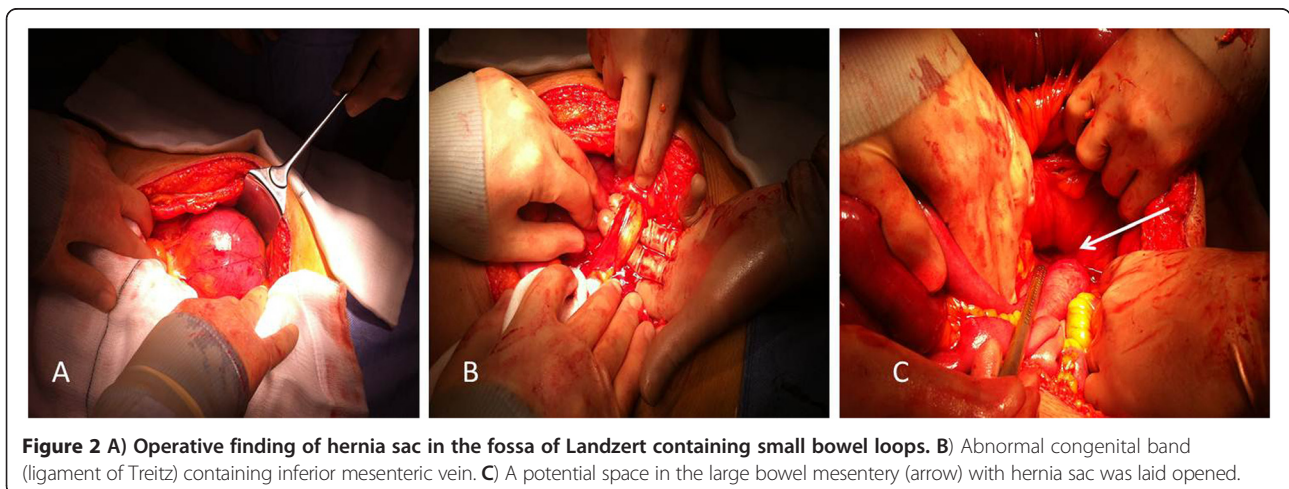


Table 1 Reported cases of left paraduodenal hernia

| Author, year | Age (years) | Gender | Chronic symptoms | Small bowel obstruction | Left paraduodenal hernia confirmed on imaging | Emergency/elective surgery | Laparotomy | Laparoscopic |
|--------------------------------|-------------|--------|------------------|-------------------------|---|----------------------------|------------|--------------|
| Chatterjee et al., 2012 [11] | 55 | Male | - | Yes | - | Emergency | Yes | - |
| Bhatti et al., 2012 [12] | 18 | Female | - | Yes | - | Emergency | Yes | - |
| Akbulut et al., 2012 [13] | 42 | Male | - | Yes | - | Emergency | Yes | - |
| Hussein et al. 2012 [14] | 59 | Female | - | Yes | Yes | Emergency | - | Yes |
| Fernandez-Ray et al. 2011 [15] | 39 | Male | - | Yes | Yes | Emergency | Yes | - |
| Downes et al., 2010 [16] | 47 | Male | Yes | - | - | Emergency | Yes | - |
| Parmar et al., 2010 [17] | 38 | Male | Yes | - | - | Elective | - | Yes |
| Khalaileh et al., 2010 [5] | 53 | Female | - | Yes | Yes | Emergency | - | yes |
| Yun et al., 2010 [18] | 28 | Male | - | - | Yes | Emergency | Yes | - |
| Uchiyam et al., 2009 [19] | 80 | Female | Yes | - | - | Elective | - | Yes |
| Poultides et al., 2009 [20] | 67 | Female | - | Yes | - | Emergency | - | Yes |
| Kuzinkovas et al., 2008 [21] | 59 | Male | - | - | - | Elective | Yes | - |
| Peters et al., 2008 [22] | 76 | Male | - | Yes | Yes | Emergency | Yes | - |
| Jeong et al., 2008 [23] | 52 | Male | - | Yes | - | Emergency | - | Yes |
| Jeong et al., 2008 [23] | 58 | Female | - | Yes | - | Emergency | - | Yes |
| Palanivelu et al., 2008 [24] | - | Male | - | - | Yes | Elective | - | Yes |
| Palanivelu et al., 2008 [24] | - | Male | - | Yes | Yes | Emergency | - | Yes |
| Palanivelu et al., 2008 [24] | - | Female | - | Yes | Yes | Elective | - | Yes |
| Shoji et al., 2007 [25] | 60 | Male | - | - | - | Emergency | - | Yes |
| Papaziogas et al., 2007 [26] | 35 | Female | - | Yes | - | Emergency | Yes | - |
| Moon et al., 2006 [27] | 18 | Male | - | Yes | - | Emergency | - | Yes |
| Brehm et al. 2006 [28] | 54 | Female | Yes | - | Yes | Emergency | Yes | - |
| Thoma et al., 2006 [29] | 72 | Female | Yes | - | - | Elective | Yes | - |
| Cingi et al., 2006 [30] | 30 | Male | Yes | - | - | Emergency | Yes | - |
| Kurachi et al., 2006 [31] | 47 | Female | - | Yes | - | Emergency | Yes | - |
| Huang et al., 2005 [32] | 24 | Male | Yes | Yes | - | Emergency | Yes | - |
| Ovali et al., 2005 [33] | 52 | Female | Yes | - | Yes | Refused surgery | - | - |
| Fukunaga et al., 2004 [34] | 51 | Male | Yes | Yes | Yes | Emergency | - | Yes |
| Rollins et al., 2004 [35] | 21 | Male | Yes | - | Yes | Elective | - | Yes |
| Patti et al., 2004 [36] | 46 | Male | Yes | - | - | Elective | Yes | - |
| Catalano et al., 2004 [37] | 82 | Male | - | Yes | Yes | Emergency | Yes | - |
| Goodney et al., 2004 [38] | 75 | Male | Yes | - | - | Elective | Yes | - |
| Tong et al., 2002 [39] | 30 | Male | Yes | - | - | Elective | Yes | - |
| Nishida et al., 2001 [40] | 47 | Male | Yes | - | Yes | Elective | Yes | Yes |
| Patil et al., 1999 [41] | 29 | Female | - | - | Yes | Emergency | Yes | - |
| Schaffler et al., 1999 [42] | 26 | Male | Yes | - | Yes | Elective | Yes | - |
| Uematsu et al., 1998 [43] | 44 | Male | Yes | - | - | Elective | - | Yes |
| Hirasaki et al., 1998 [44] | 28 | Female | Yes | - | Yes | Elective | Yes | - |
| Mcdonagh et al., 1996 [45] | 52 | Male | - | Yes | - | Emergency | Yes | - |
| Suchato et al., 1996 [46] | 40 | Male | - | Yes | - | Emergency | Yes | - |
| Suchato et al., 1996 [46] | 52 | Male | Yes | - | - | Emergency | Yes | - |
| Warshauer et al., 1992 [47] | 42 | Female | Yes | - | Yes | Elective | Yes | - |
| Toit et al., 1986 [48] | 22 | Male | - | Yes | - | Emergency | Yes | - |
| Tireli et al., 1982 [49] | 18 | Male | - | Yes | - | Emergency | Yes | - |

the posterior gastric wall and distal part of the duodenum. Besides, there is engorgement and crowding of the mesenteric vessels with frequent right displacement of the main mesenteric trunk and depression of the transverse colon (Figure 1).

Once a LPDH is identified, operative treatment is necessary, as patients with a LPDH have a 50% lifetime risk of developing small bowel obstruction with a 20–50% mortality rate for acute presentations [6,8]. In this review, 28 patients (67%) underwent emergency surgery. Of those 43 patients, 15 patients had laparoscopic repair of LPDH. Surgical intervention included reduction of the herniated small bowel loops and closure of the hernia orifice with non-absorbable sutures or a mesh [5,24]. A different possibility was to widen the hernia orifice to prevent future incarceration of bowel loops [5]. Often, there is a close anatomical relationship between the inferior mesenteric vein which bound the hernia anteriorly, and the hernia orifice [5,24]. Therefore, division of the inferior mesenteric vessels at the neck of the sac may be necessary, as in this case, when the incarcerated bowel could not be reduced easily from the hernia [24].

Conclusion

Left paraduodenal fossa hernia is a relatively a rare cause of small bowel obstruction. In young patients with recurrent small bowel obstruction with no previous surgical history, it is crucial to consider internal hernias in the differential diagnosis. Furthermore, a timely and correct diagnosis is together with prompt surgical intervention is essential for achieving patient's cure and prevents future complications.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

WAK, SA, JB, and TER prepared the manuscript. TER outlined the manuscript's layout and supervised the work. All authors read and approved the final manuscript.

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