Occult Internal Hernia Causing Oral Aversion and Parenteral Nutrition Dependence

University Hospitals

Ahmed M. Ali MD, Ryan Juza MD

Case Western Reserve University EST. 1826
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Background

Internal hernias can develop any time following Roux- en -Y reconstruction. They account for <1% of acute bowel obstructions but can be life threatening due to strangulation. They rarely present in a chronic fashion. Here we describe a case of occult internal hernia causing chronic abdominal pain and parenteral nutritional dependence.

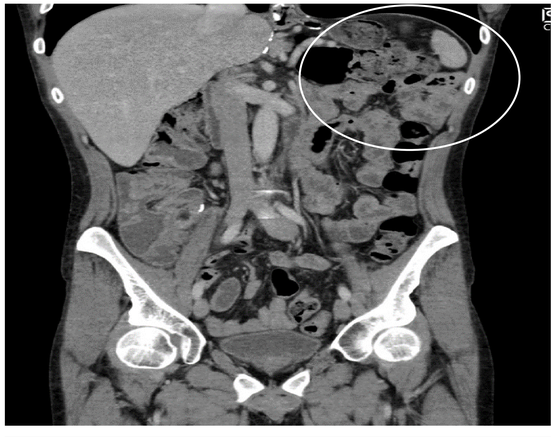
Methods

Herein, we evaluate a 36-year-old male with a history of multiple foregut operations since birth. His index operation was a laparoscopic Nissen fundoplication in childhood resulting in feeding intolerance. He underwent multiple reoperations in attempt to correct the feeding intolerance but ultimately required total gastrectomy with esophagojejunostomy in his 20s. Following that he developed chronic postprandial pain and subsequent oral aversion requiring TPN.

Imaging was reportedly non-diagnostic. Endoscopic workup revealed no abnormalities. Splanchnic nerve radiofrequency ablation was attempted without improvement. He was diagnosed with malingering and maintained on TPN. On regular follow-up, he was found to have an incisional hernia and was referred to a hernia surgeon. Review of CT imaging revealed mesenteric swirling and fecalized small bowel in the left upper quadrant; chronic internal hernia was suspected.

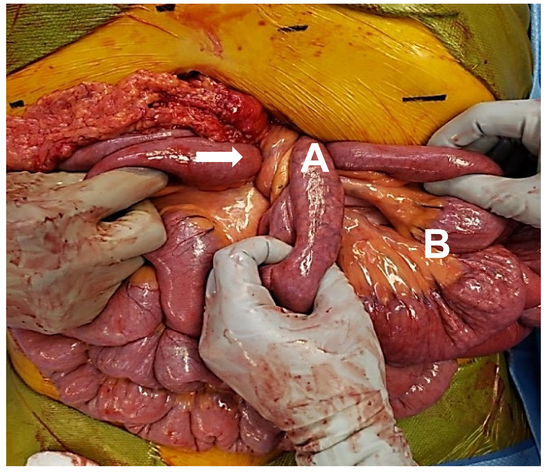
Figures

Cross sectional imaging demonstrating small bowel fecalization in the left upper quadrant.





Intraoperative photo demonstrating right to left herniation of distal small bowel- (A) Alimentary limb. (B) Herniated bowel. (arrow) Mesenteric defect.



Results

He underwent an exploratory laparotomy revealing herniation of small bowel through Peterson's defect with chronic venous and lymphatic congestion but no ischemia. The bowel was reduced, and the mesenteric defect closed. A feeding jejunostomy tube was placed and the abdominal wall hernia was repaired. Postoperatively he was started on soft diet and TPN was weaned on post op day 4. He was discharged on post op day 6 on a regular diet with supplemental tube feeds.

At one month follow up the patient's nausea and pain had resolved, and he was tolerating 100% caloric intake by mouth. His tube feeds were stopped and jejunal feeding tube was discontinued two months post op. At one year follow up the patient continues to take all nutrition orally and his chronic abdominal pain has resolved.

Conclusion

Internal hernias are an increasingly common occurrence as the prevalence of gastrointestinal reconstruction increases. They can be difficult to diagnose, particularly in a chronic fashion, but carry a high morbidity and mortality. Internal hernia should remain in the differential diagnosis of any patient with gastrointestinal reconstruction who presents with abdominal pain and oral intolerance as failure to diagnosis this can have significant consequences.