FALCIFORM LIGAMENT HERNIA: A Rare Cause of Small Bowel Obstruction

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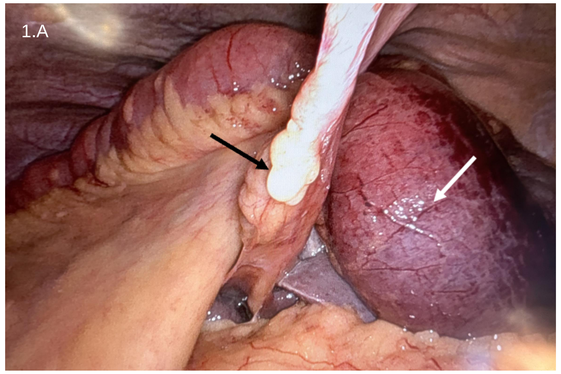
Introduction

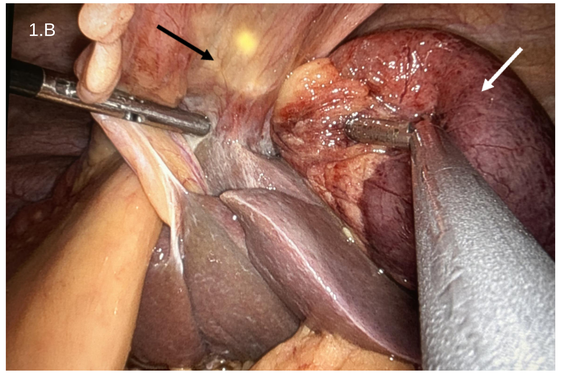
Herniations of the small bowel are the second leading cause of small bowel obstruction in the United States. Falciform ligament hernia refers to a subset of internal hernias involving a defect through the falciform ligament. This remains a rare form of internal hernia, accounting for only 0.2% of all internal hernias. Despite imaging, falciform ligament hernia is difficult to diagnose pre-operatively and requires a high index of suspicion for early recognition and treatment.

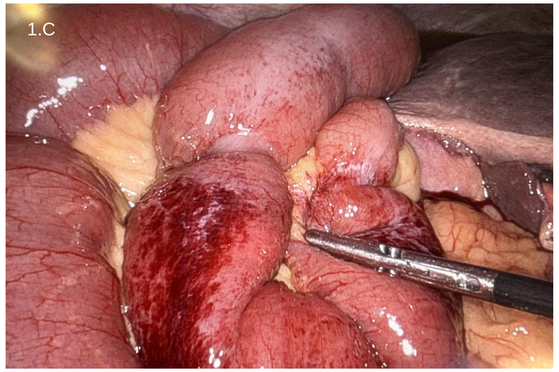
Case Presentation

A 78 y/o male with no prior PMHx or PSHx presented to the ED as a transfer for small bowel obstruction. He reported diffuse abdominal pain and no bowel movements or flatus x 1 week with constipation, obstipation, nausea and emesis.

VSS. Labs showed WBC 9.6, lactate 4.9, sodium 131, potassium 4.0, BUN 104, and creatine 2.6. Abdomen was soft but distended with diffuse tenderness with no rebound, guarding, nor peritonitis. NGT was placed and had >1L feculent bilious output. CT scan of abdomen and pelvis demonstrated distended loops of small bowel with decompressed loops distally but no clear transition point.







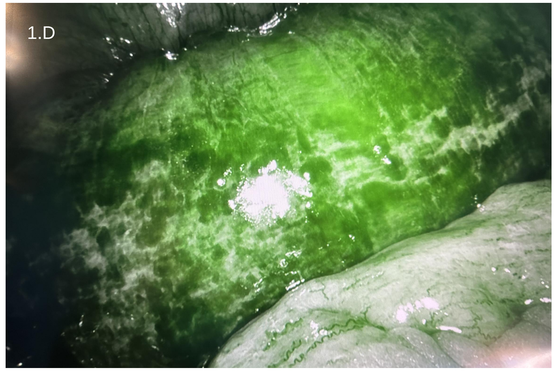
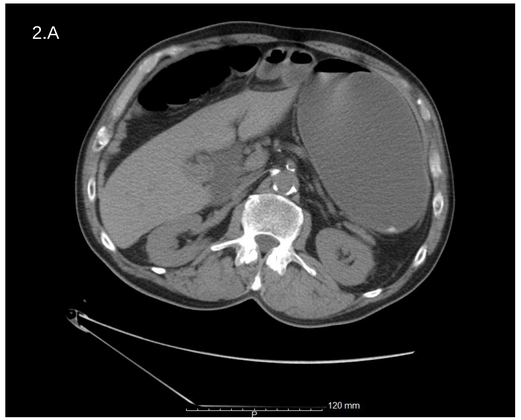


Figure 1.A-1.D: Intraoperative findings during diagnostic laparoscopy. Patient was found to have a falciform ligament hernia with a strangulated loop of small bowel (white arrow) protruding through a defect in the falciform ligament (black arrow) (1.A, 1.B). Falciform ligament was divided and small bowel was released. Dilated proximal and decompressed distal loops were identified (1.C). Bowel was hyperemic but viable with peristalsis, re-equilibration throughout case, and ICG illumination (1.D).



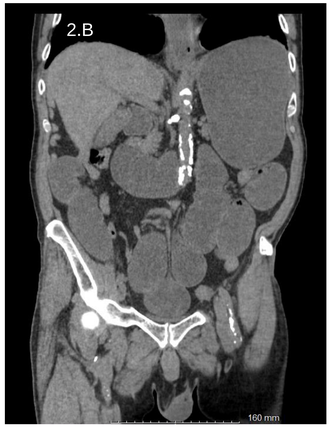


Figure 2.A: CT abdomen and pelvis axial view demonstrates gastric distension and dilated small bowel loops lying anterior to liver.
Figure 2.B: CT abdomen and pelvis coronal view demonstrates gastric distension and dilated loops of small bowel throughout abdomen.

Intervention

Due to concerns of bowel ischemia and lack of prior surgical history, the decision was made to take the patient for diagnostic laparoscopy. Upon exploration of the abdomen, a falciform ligament hernia with incarcerated small bowel was found and released. ICG confirmed bowel was viable with no evidence of necrosis. The patient recovered without any complications.

Conclusion

This case highlights the difficulty in diagnosing falciform ligament hernia pre-operatively as well as the importance of early operative intervention to avoid the need for small bowel resection and associated morbidity.

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