Presentation and Treatment of a Lesser Sac Internal Hernia

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Introduction

Internal hernias are rare causes of bowel obstruction, usually associated with a prior history of abdominal surgery such as a Roux-en-Y bypass. Herniation into the lesser sac is an exceptionally rare case with small anatomic openings for a hernia to occur. Abdominal contents herniate through the foramen of Winslow causing obstruction.

We present a case of a patient presenting with abdominal pain of uncertain origin. The patient underwent multiple tests and consultants to find a source of her pain. With an unclear mix of unremarkable imaging or labs, the patient was ultimately brought to the operating room for diagnostic laparoscopy where the source of her pain was able to be identified and treated.

Case Discussion

Patient is a 52yo female who presented to the emergency room for intractable abdominal pain. The pain was located mostly in the right upper quadrant and did not improve with administration of pain medication. She denied any nausea or vomiting symptoms. Initial work up involved a RUQ ultrasound which showed a contracted gallbladder and hemangioma of the liver. A WBC was 5.3 and normal lactic. A CT scan of the abdomen was then performed which, on initial read, did not show any acute abnormalities.

With a negative workup at this point, gastroenterology was consulted for EGD with a concern for possible peptic ulcer disease as the cause of the patient's symptoms. An EGD was

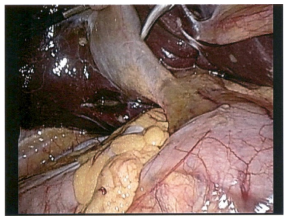


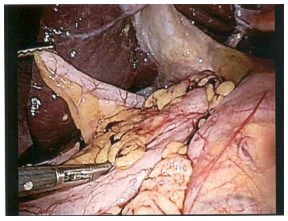


performed and showed some gastritis with concern for possible extrinsic compression on the lesser curve. A HIDA scan was then performed which showed no filling of the gallbladder.

At this time, the patient continued to have significant pain, and with no other signs of abnormality, it was decided to bring the patient to the operating room for diagnostic laparoscopy and possible cholecystectomy.

On entry to the abdomen, the gallbladder was grasped and elevated. It was then noted that the patient's right colon was behind the cystic duct. A foramen of Winslow hernia was then identified. The hernia was difficult to reduce so the case was converted to open. It was then possible to safely reduce the





hernia carefully. The colon was noted to be very redundant and mobile. Due to concern for future incarceration, it was decided to proceed with a right colectomy with anastomosis. The patient was then closed and brought to the floor. Her symptoms improved following the surgery, and she was able to be discharged with out complication. She did return a year later for a cholecystectomy due to symptoms of cholelithiasis.

Conclusion

Hernias through the foramen of Winslow are very rare with few reported cases. This patient's presentation highlights the difficulty in diagnosis. On a second review of the CT scan, the hernia was able to be identified on imaging by tracing the course of the colon. There was no decompressed distal bowel as can usually be expected at a site of obstruction, which made the diagnosis more difficult in addition to the rare presentation. Most cases appear to be caused by excessive visceral mobility, enlargement of the foramen of Winslow, or changes in intraabdominal pressure. The treatment of these rare hernias is debated. Other similar cases have reported similar colon resection to prevent an excessively mobile colon from herniating again, closure of the foramen, or a combination of both.

References

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