

Patient Presentation

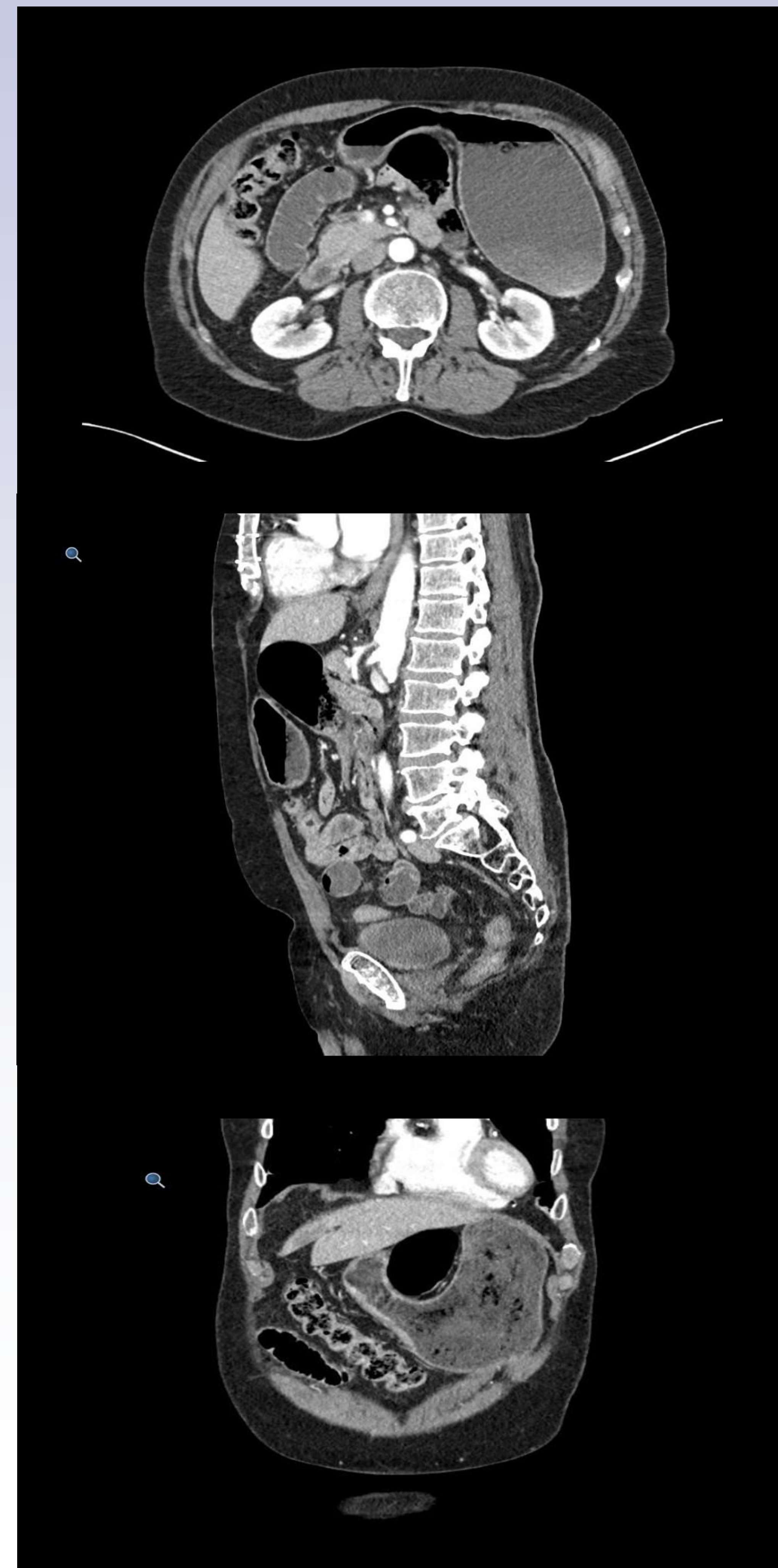
81M presented to emergency department with 12 hours of epigastric pain, nausea and emesis. He was continuing to pass flatus and stool. His past medical history was significant for CAD, PAD, and hypertension. He has no prior abdominal surgical history. He was afebrile and hemodynamically normal.

11.4 15.2 307 45.3

Lactic acid: 1.8

Upon abdominal exam the patient was minimally tender in the epigastrium, he was non-distended, there was no rebound tenderness or guarding. CT demonstrated fluid-filled distended loops of small bowel in the right abdomen. More distally, the small bowel loops are slightly decreased in caliber with long segment small bowel wall thickening and surrounding inflammatory change. The cecum extends into the lesser omentum located at the lesser curvature of the stomach and undersurface of the left lateral hepatic lobe. There was no pneumatosis or portal venous gas. Given the patient's clinical stability, and lack of radiologic or imaging findings consistent with ischemia, he was admitted to the hospital for nasogastric decompression and medical optimization. NGT output over the first 24 hours was 1100cc, an echocardiogram was performed that demonstrated an ejection fraction of 60%. After shared decision making the patient elected to proceed with robotic diagnostic laparoscopy, reduction of internal hernia and Cecopexy.

CT Imaging



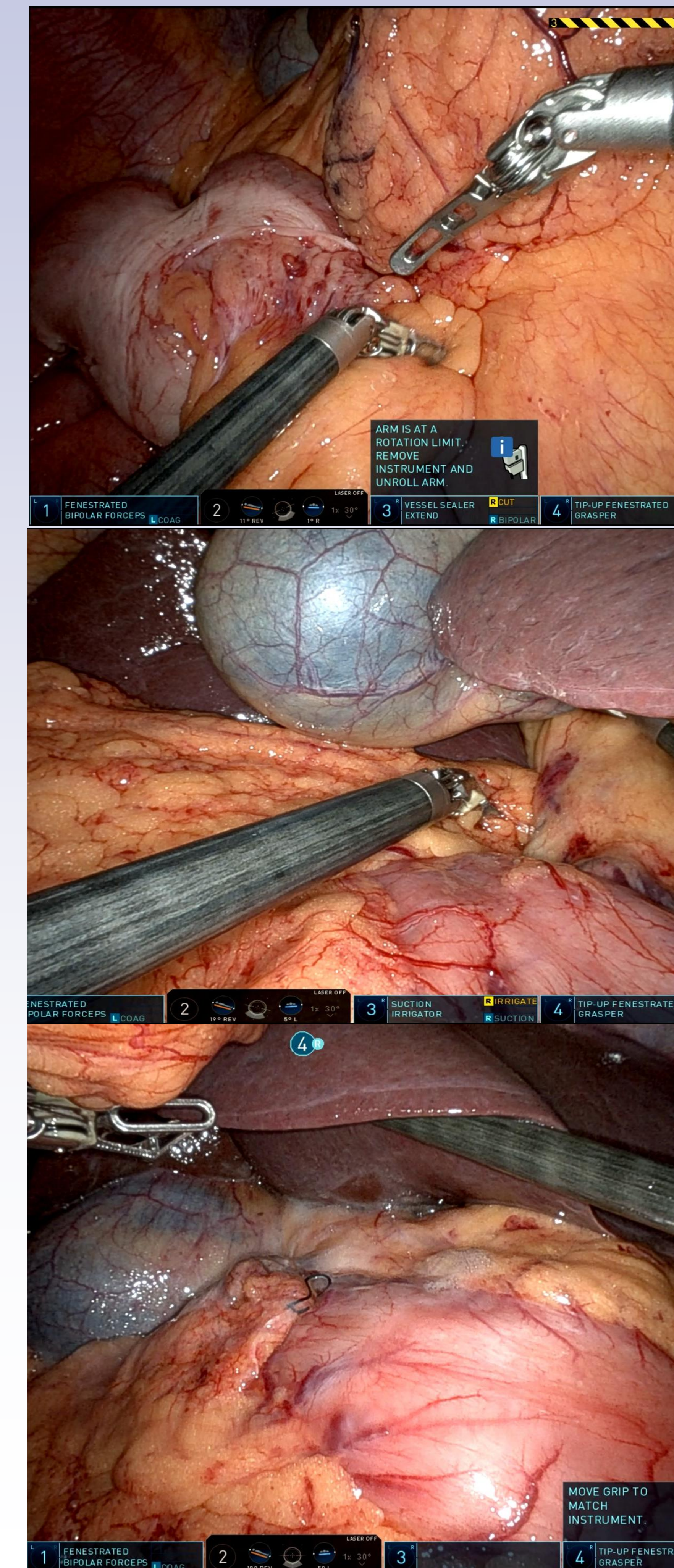
Operative Technique

A Veress was used to enter the abdomen at Palmer's point. Three additional trocars were placed in a diagonal linear fashion from the left upper quadrant to the right lower quadrant. There was minimal adhesive disease of the small bowel, and all small bowel and colon was healthy in appearance. The cecum was noted to be in the Foramen of Winslow, it was gradually reduced with Gentle pressure and a cecopexy was performed with 0-silk sutures. The omentum was secured to the anterior stomach closing the foramen of Winslow, and vistaseal was applied to the entire area surrounding the previous defect.

The following images (ordered from top to bottom) show key portions of the operation. The first image shows the reduction of the cecum and omentum. The second image shows the resultant defect into the lesser sac through which the cecum was herniated. Finally, the third image displays the defect after omentopexy and vista seal application. The cecum was pexied to the right abdominal sidewall which is not displayed here.

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Intra-Operative Findings



Post-op

The patient tolerated surgery without issue and was transferred back to the floor. He began passing flatus and his nasogastric tube was removed on post operative day 1. His Diet was advanced to clear liquids on post op day 1, and then to regular diet on post op day 2. His post-operative pain was well managed, he had demonstrated return of bowel function, and he was ambulating on the ward. He was discharged to home on post-operative day 3.

He was seen in clinic 3 weeks post-operatively where he denied any recurrence of his symptoms, and he was continuing to tolerate regular diet with normal bowel habits.

Conclusion

Foramen of Winslow hernia is a rare cause of internal hernia with surgical approach dependent on patient conditions, surgeon preference/skill, and the resources available. There are previous reports of both open and laparoscopic repairs, however, ours is the first reported case of a robotic assisted repair

Acknowledgments

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