



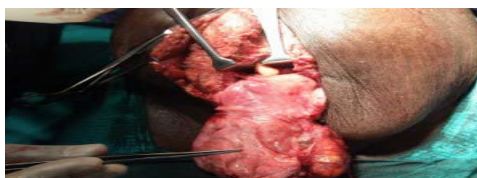
## INCISIONAL HERNIA OF THE URINARY BLADDER IN AN ACHONDROPLASTIC PATIENT - A CASE REPORT

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**Abstract :** Abdominal hernias are not rare in women, but incisional bladder herniation is uncommon. Incisional hernias are an iatrogenic condition caused by protrusion of the abdominal viscera through the abdominal fascia. Omentum and small intestines are by far the most common viscera involved, and the condition is diagnosed on clinical examination either visually or by palpation of an abdominal bulge. We describe a case of bladder herniation through a Right lower para median incision for caesarean section.

**Keyword :** INCISIONAL HERNIA, URINARY BLADDER



### INTRODUCTION

An incisional hernia is an iatrogenic condition *where* an abdominal organ protrudes from its normal location via a defect of the abdominal fascia. Many factors are involved in the development of this condition. These include

patient-related factors (poor healing of the wound due to obesity, the use of steroids, chronic illnesses like diabetes mellitus, chronic obstructive pulmonary disease, etc.); surgery-related factors (inappropriate technical procedure used for wound closure during previous operations) and postoperative complications (wound infections, postoperative ileus, etc.). The incidence of an incisional hernia is estimated to be about 4% following abdominal operations [1]. The small intestines and omentum are the most frequently herniated organs [1]. Involvement of the urinary bladder in inguinal hernias is not rare but isolated incisional herniation of the bladder is very rare. The present report describes a case of incisional bladder hernia following caesarean section.

### CASE REPORT

A 52 years old Achondroplastic female patient presented to our hospital with the two years history of swelling adjacent to the right lower para median scar. (Patient underwent two caesarean sections at the age of 25 and 28 years). The swelling was reducible earlier. And became non reducible for the past 3 days. There was a history of dull aching pain over the swelling. Pain was not radiating or referring. There was no history of vomiting or constipation. There was no fever. There was no difficulty in micturition. On General examination, patient was with Achondroplastic features. Patient was conscious, oriented, afebrile, with no pallor and cyanosis. There was no pedal edema and generalised lymphadenopathy.

On examination of the abdomen, it was distended, with a swelling of size 10\*8 cm in the hypogastrium adjacent to the scar extending upto 3 cm below the umbilicus. There was no visible peristalsis. Cough impulse was absent. On palpation, swelling was not warm. Tenderness was present. It was not reducible. No other mass was palpable. There was no organomegaly. Cardio vascular, Respiratory and Central Nervous systems examination were normal. Complete Blood count, Renal function tests and electrolytes were within normal limits. Chest xray, ECG were normal. Patient was diagnosed irreducible incisional hernia and taken to the Operation theatre for exploration and repair. Patient was foley's catheterised. Per operative findings were as follows. There was a 8\*6 cm sac herniating from the defect in the rectus sheath. The content of hernia sac included only urinary bladder

without intestinal segments. Content was reduced . Rectus sheath defect was closed. Large Prolene mesh kept over the defect and the adjacent area. Suction drain kept. Wound closed in layers. Post op was uneventful. Catheter and Drain was removed on the fifth post operative day. Sutures were removed. Patient was discharged and followed up. During the follow-up period, neither recurrent hernia nor urinary system dysfunction developed.

#### **DISCUSSION**

Herniation of the bladder is primarily described in association with inguinal and femoral hernias. Urinary bladder is involved in 1-3% of inguinal hernias. The known risk factors for urinary bladder herniation are chronic bladder distention due to outlet obstruction, weakness of supporting structures, pericystitis, and pelvic masses. Although several cases of incisional bladder herniation after urologic operations have been reported, to the best of our knowledge, this is the first case of bladder herniation after caesarean sections<sup>2</sup>. The urodynamic evaluation of our patient ruled out any urinary outflow obstruction leading to herniation. Therefore, possible causes of herniation in our patient might be fascial defect proximal to bladder.

#### **CONCLUSION**

Incisional hernias are serious complications of abdominal operations. Commonly stated risk factors for incisional hernias are wound infection, old age, obesity, underlying diseases, malnutrition, and reoperation. Parapubic hernia is an uncommon variety of incisional hernias. The specific risk factors for parapubic hernia are pelvic surgery<sup>4,5</sup>, dissection of musculotendinous attachments of the abdominal wall to the pubic bone, and trauma. In order to avoid complications of urinary bladder herniation such as possible upper tract obstruction, strangulation, infarction, and perforation of the bladder, hernias must be repaired by open or laparoscopic approaches. Although laparoscopic technique is currently recommended , we preferred open technique in order to avoid complications related to postoperative visceral adhesions. Additionally, open technique allowed primary closure and reinforcement of fascia with only mesh<sup>3</sup>. Isolated incisional herniation of urinary bladder can be successfully repaired with open technique and mesh reinforcement if the function of the bladder is normal.

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