

Case Report

POSTOPERATIVE VENTRAL HERNIA, GRADUALLY CONDUCTED INTO "CHRONIC" EVISCERATION": REPORT OF A CASE

***Georgia K. Korfiati, Panayiota Papamikrou and Vassileios Alivizatos**

Department of General Surgery, General Hospital of Patra, Patra, Greece

**Author for Correspondence*

ABSTRACT

Evisceration is an emergency situation and should always be treated as such. However, in this case report is described a remarkable case of an incisional hernia which gradually, within two years, concluded to evisceration without causing any symptoms.

Keywords: Hernia, Postoperative, Evisceration, Chronic, Reconstruction

INTRODUCTION

Evisceration is a rare but severe surgical complication where the surgical incision opens and the abdominal organs protrude or come out of the incision. Common causes are technical failure of sutures, shear forces from tension, or fascial necrosis due to infection and/or ischemia. The most frequently eviscerated abdominal organs are the great omentum and parts of the small bowel which protrude through the separated fascia; the latter is of greatest importance because it poses the potential risk of mechanical injury or desiccation of the intestinal wall, frequently leading to perforation or fistulization of the bowel. Evisceration is an emergency and should always be treated as such.

CASES

A 75-year-old female patient was admitted to the surgical department of our hospital to undergo a scheduled operation for postoperative ventral hernia. From her surgical background, she underwent an abdominal hysterectomy along with omentum excision two years ago, due to ovarian cancer; a year later, a midline postoperative hernia was appeared which gradually increased in size. In the clinical examination, the skin has subsided and it has been replaced by a thin transparent membrane covering the underlying intestine which concluded as a part of the abdominal wall (Figure 1).

In the surgical procedure, under general endotracheal anesthesia, the exposed intestine was initially detached from the partially overlying skin (Figure 2), it was carefully cleansed and it was restored into the peritoneal cavity (Figure 3).

Finally, the defect was repaired, the unviable overlying skin was excised, a soft rubber drainage tube was placed, and the incision was closed in healthy edges with the sage of tension stitches (Figure 4). The postoperative course was uneventful and the patient was discharged from the hospital on the third postoperative day.

At the above-mentioned case, the protruded part of the small bowel eroded the overlying skin gradually resulting to the small bowel as a part of the abdominal wall, without causing any symptoms, a situation which could be characterized as "chronic" evisceration.

The diagnosis of evisceration is purely a clinical observation. Fascial separation is usually heralded by discharge of serous, bloody, or suppurative fluid from a closed wound. Opening the wound confirms the fascial separation. Fascial separation in the already open wound is readily seen.

Prevention of evisceration entails avoidance of infection or technical errors in closure, minimization of tension on the wound closure, and avoidance of wound ischemia. Little objective evidence supports reduced evisceration rates from one type of suture over another. Monofilament, large caliber, non-absorbable sutures have appeal. Interrupted versus running techniques have comparable evisceration rates. Retention sutures reduce evisceration risks but not the frequency of dehiscence (the separation of the fascial closure).

Case Report

In this report, we presented a case of a postoperative ventral hernia where the protruded part of the small bowel eroded the overlying skin, gradually resulting of the former as a part of the abdominal wall, without causing any symptoms. This situation, which could be named “chronic” evisceration, represents the first reported case of a postoperative ventral hernia which gradually, within two years, resulted in “chronic” evisceration, being the small bowel a part of the abdominal wall.

Although evisceration is an emergency and should always be treated as such, our reported case is not characterized as an emergency situation because gradually resulted to the small bowel as part of the abdominal wall without causing any symptoms. As, to our knowledge, there is no similar report in the international bibliography, this case was presented and analyzed for this reason.



Figure 1: Postoperative Hernia with Transparent Membrane Covering the Underlying Bowel which Concluded as a Part of the Abdominal Wall

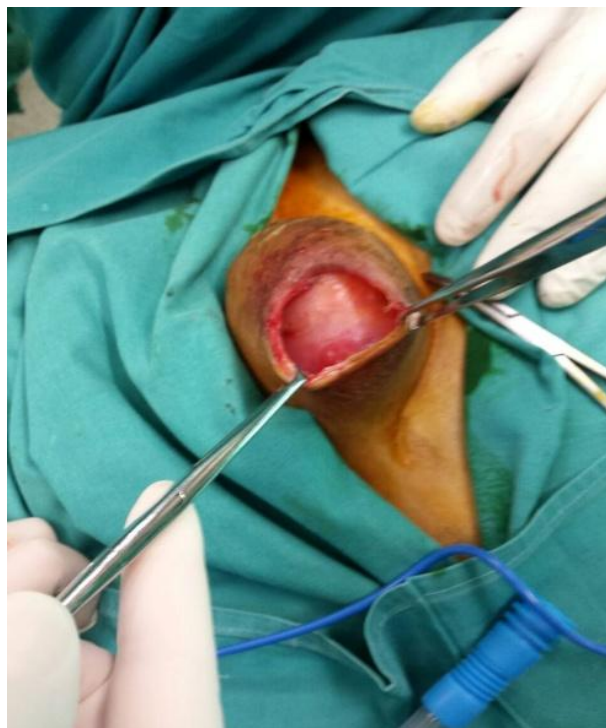


Figure 2: The Exposed Intestine Detached from the Overlying Skin

Case Report



Figure 3: The Exposed Intestine was Carefully Cleansed and it was Restored into the Peritoneal Cavity



Figure 4: The Incision was Closed in Healthy Edges

Case Report

REFERENCES

Friedman MHW (1965). Spontaneous Evisceration through a Ventral Hernia. *Canadian Medical Association Journal* **92**(13) 670–671 - PMID: PMC1928243.

Henry MM (2005). *Clinical Surgery*, Second edition, (Blackwell Publishing Company, Massachusetts, USA) - ISBN: 978-960-394-450-8

Holzheimer RG and Mannick JA (2001). *Surgical Treatment Evidence-Based and Problem-Oriented*, (München, Germany: W. Zuckschwerdt Verlag) ISBN: 3-88603-714-2

Diaz SE (2005). *The Little Black Book of Emergency Medicine*, 2nd Edition, (Jones & Bartlett Learning, Massachusetts, USA).

Longmore M et al., (2010). *Oxford Handbook of Clinical Medicine*, 8th edition, (Oxford University Press, Oxford, UK) - ISBN: 978-0-19-923217-8

Mudge M and Hughes E (1985). Incisional hernia: a 10 year prospective study of incidence and attitudes. - *British Journal of Surgery* **72**(1) 70-1 - PMID: 3155634

Rather AA (2015). *Abdominal Hernias Treatment & Management* - ISBN 978-1-84882-877-3