

SPIEGEL HERNIA AFTER VIDEOLAPAROSCOPIC CHOLECYSTECTOMY: A CASE REPORT

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Abstract: Spiegel's hernia is a rare entity and represents a defect in the abdominal wall on the outer edge of the semilunar line, being a diagnostic challenge due to the nonspecific symptomatology. Risk factors for the condition include obesity, multiparity, chronic obstructive pulmonary disease, ascites and chronic constipation. We present in this work a case report on the emergence of a Spiegel's Hernia after performing a videolaparoscopic surgery, correlating the increase in intra-abdominal pressure during the procedure with its origin.

Keywords: Hernia, Spiegel, CVL

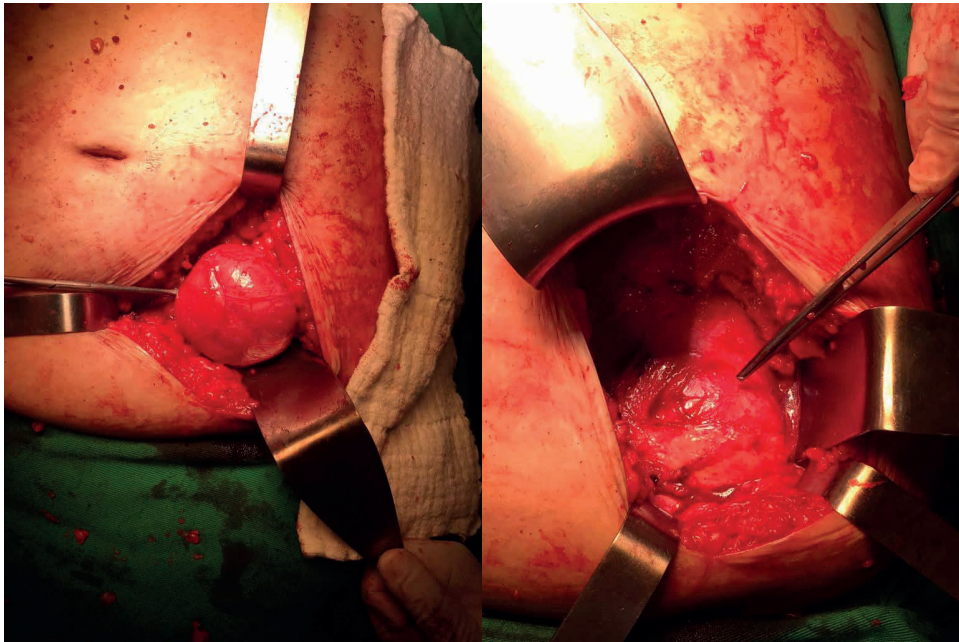
INTRODUCTION

Spiegel's Hernia (SH) is a rare entity (0.12-2% of abdominal hernias), and represents a defect in the abdominal wall at the junction of the lateral edge of the rectus abdominis muscle and the medial edge of the transversus abdominis muscle, occurring in the semilunar line below the umbilicus, with congenital or acquired etiology^{2,3}. It consists of the protrusion of a peritoneal sac that may contain omentum, small intestine, sigmoid and transverse colon, cecum, appendix or Meckel's diverticulum, or even preperitoneal fatty tissue¹. Due to the non-specific symptomatology, it can be a diagnostic challenge². In most cases, it affects women in their fourth decade of life with risk factors that increase intra-abdominal pressure (IAP) or weaken the abdominal fascia, such as: obesity, multiparity, chronic obstructive pulmonary disease, ascites and chronic constipation. These hernias are usually indicated for surgery due to the risk of entrapment that can occur in about 25% of patients^{3,5}. The surgery can be by anterior approach or by videolaparoscopic approach¹.

CASE REPORT

S. S. M., female, 48 years old, obese, with chronic constipation. History of laparoscopic

cholecystectomy (CVL) 2 years ago. She reports that after the surgery she noticed the presence of a painless nodule in the left flank (FE). 1 year ago, she underwent an ultrasound (US) of the abdominal wall, however, without alterations; after 5 months, in a new exam, HS was found with abdominal content lateral to the rectus abdominis muscle, in the EF, through a 2.7 cm neck, with intestinal loops going beyond the abdominal aponeurosis and reaching the muscle planes, without reaching the adipose tissue subcutaneous. Computed tomography (CT) performed 1 month ago, confirmed the diagnosis of HS on the left, with no signs of complications. Admitted to the local service for an elective procedure for left herniorrhaphy, the patient had a globular abdomen, normotensive, painless on palpation, without signs of peritoneal irritation or palpable masses. The surgery was performed uneventfully, under general anesthesia, with a transverse incision in FE, identifying the hernial ring and muscle failure, proceeding with dissection, reduction, mesh fixation, insertion of a Portovac drain, hemostatic review and closure by plans. The patient evolved well postoperatively and was discharged after 3 days without complications.



Figures 1 and 2. Exposure of the hernia sac.



Figure 3. Fixing the screen.



Figure 4. Cavity after correction.

DISCUSSION

The case presented is typical of an HS. Female patient, in the usual age range, presenting risk factors (obesity, constipation) and difficult diagnosis, due to nonspecific symptoms, anatomical location and even failure in imaging tests. However, what draws

our attention was the fact that this hernia was discovered shortly after an LVC. As mentioned, risk factors for HS are conditions that elevate the IAP, which is the case with this procedure. Guimaraes et al. (1997), reports the diagnosis of HS after abdominoplasty, relating its emergence to this same reason. Although the evidence is still not strong, we can begin

to consider that intra-abdominal surgeries with IAP increase can accentuate symptoms or even be related to the appearance of HS in patients who already have other risk factors for it. Studies with a larger sample of similar cases would be able to show us such strength of association. Thus, a good anamnesis can help guide our clinical suspicions, anticipating

a possible late diagnosis. The treatment of this pathology is surgical, as this hernia has a high rate of complications (21-33%), such as incarceration and strangulation². When elective, the technique can be either laparoscopic or open, at the discretion of the surgeon and local resources.

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