M1 - Renal, Fall 2007

Lyons, R.; Burney, R.

<http://hdl.handle.net/2027.42/64946>
http://hdl.handle.net/2027.42/64946
Unless otherwise noted, the content of this course material is licensed under a Creative Commons Attribution 3.0 License
http://creativecommons.org/licenses/by/3.0/

Copyright 2007, Richard E. Burney.

The following information is intended to inform and educate and is not a tool for self-diagnosis or a replacement for medical evaluation, advice, diagnosis or treatment by a healthcare professional. You should speak to your physician or make an appointment to be seen if you have questions or concerns about this information or your medical condition. You assume all responsibility for use and potential liability associated with any use of the material.

Material contains copyrighted content, used in accordance with U.S. law. Copyright holders of content included in this material should contact open.michigan@umich.edu with any questions, corrections, or clarifications regarding the use of content. The Regents of the University of Michigan do not license the use of third party content posted to this site unless such a license is specifically granted in connection with particular content objects. Users of content are responsible for their compliance with applicable law. Mention of specific products in this recording solely represents the opinion of the speaker and does not represent an endorsement by the University of Michigan.

Viewer discretion advised: Material may contain medical images that may be disturbing to some viewers.
Clinical Correlation: Abdominal Wall Hernias

Richard E. Burney, MD
Professor of Surgery

Source: Museu d'Arqueologia de Catalunya
Hernia: The protrusion of tissue through a defect in fascial and/or muscular layer(s) that normally contain it.

- The *sine qua non* of a hernia is a bulge.
- 16th century illustration of femoral hernia
<table>
<thead>
<tr>
<th>Types of abdominal wall hernia</th>
<th>Location</th>
<th>Congenital</th>
<th>Acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epigastric</td>
<td>Upper midline</td>
<td>*</td>
<td>?</td>
</tr>
<tr>
<td>Umbilical</td>
<td>Umbilicus</td>
<td>*</td>
<td>?</td>
</tr>
<tr>
<td>Inguinal/femoral</td>
<td>Groin</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Incisional</td>
<td>Anywhere</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Lumbar</td>
<td>Petit’s Δ</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Interparietal</td>
<td>Lateral hypogastric</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Obturator</td>
<td>Obturator foramen</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Spigelian</td>
<td>Arcuate x semilunar lines</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Traumatic</td>
<td>Anywhere</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Diastasis</td>
<td>Upper midline</td>
<td>Not a hernia</td>
<td>Not a hernia</td>
</tr>
</tbody>
</table>
Why Do Hernias Occur?

1. There is a congenital developmental defect
   - Failure of fascial opening to close (e.g., umbilical)
   - Failure of process to obliterate itself (e.g., processus vaginalis)

2. There is an acquired weakness
   - Deterioration/thinning of fascia with age
   - Loss of tissue (injury, infection, poor wound healing, etc.)
Basic Anatomy

Semilunar line

Arcuate line
Epigastric hernia

- Very common
- In midline between umbilicus and xiphoid
- May be multiple
- Small fascial defect (<1 cm)
- Tongue of preperitoneal fat through interlacing fibers of linea alba
- Peritoneal sac present only if very large.
4th - 5th century B.C.
Phoenician terracotta figure with umbilical hernia

Source: Museu d'Arqueologia de Catalunya
Umbilical Hernia

- Common in infancy
- Reacquired during adulthood
- Peritoneal sac
- Small ones of no significance
- Large ones contain omentum, small or large bowel
Typical Umbilical Hernia
Umbilical & Inguinal & Epigastric Hernias
Scrotal hernia, 1682

Hernia strap, 1758

16th century hernia repair

Source: Undetermined
Inguinal hernia

- Most common
- Most difficult to understand

- Congenital ~ indirect
- Acquired ~ direct or indirect

**Indirect Hernia**
- has peritoneal sac
- lateral to epigastric vessels

**Direct Hernia**
- usually no peritoneal sac
- through Hasselbach triangle, medial to epigastric vessels
Typical scrotal hernia
Giant scrotal hernia

- Note scaphoid abdomen
Anatomy, Nomenclature and Classification of Inguinal Hernia

The Inguinal Canal

- The anatomic space beneath the external oblique aponeurosis, between the internal and external inguinal rings.
- In men, it contains the cremaster muscle which covers the cord structures (vas deferens, testicular vessels, and associated connective tissues).
- In women, it contains the cremaster muscle, round ligament from the uterus, nerves and some connective tissues.
- Ilioinguinal & other nerves are found in or on cremaster and internal oblique muscles.
Indirect Inguinal Hernia

- Consists of peritoneal sac coming through internal ring, antero-medial to the spermatic cord (or round ligament) and into which omentum or bowel can enter.
- Usually congenital, but may be acquired.
- The majority of hernias in patients under age 25 are congenital and indirect.
- Male/female ratio is about 9:1.
- Internal ring may be normal or dilated.
- Higher risk of incarceration/strangulation if internal ring is small and hernia is large and extends into scrotum.
- [Anatomists assert that indirect hernias emerge lateral to the epigastric vessels. This is anatomically accurate but for practical purposes a pretty useless definition.]
Direct Inguinal Hernia

- Bulges into inguinal canal as a result of weakness or attenuation of the posterior floor of the inguinal canal.
- Can develop anywhere in inguinal floor from internal ring to pubic bone, and involve some or all of floor.
- Contains primarily retroperitoneal fat. However, a true peritoneal sac containing bowel is sometimes present.
- Usually low (but not zero) risk for incarceration or strangulation.
- Infrequent in women, who usually have indirect hernia.
- It does occur medial to the epigastric vessels.
- Large direct hernias can extend into the scrotum.
Sliding Hernia

- Hernia consisting of retroperitoneal fat and/or large bowel (cecum on the right, sigmoid on the left) that ‘slide’ through an enlarged internal ring, rather than into and out of an existing peritoneal sac.

- Always comes through internal ring lateral to the cord, rather than antero-medial.

Source: Undetermined
Hernia surgery
Circa 1300

~1497

~1600

17th century

Source: Undetermined
Nyhus Classification

- Type 1: indirect; congenital, normal internal ring
- Type 2: indirect; dilated internal ring, normal inguinal floor (transversalis fascia)
- Type 3: weak inguinal floor
  - 3a ~ direct hernia
  - 3b ~ indirect or sliding (acquired)
  - 3c ~ femoral
- Type 4: Recurrent
Etiology of Inguinal Hernia

- Congenital
  - All hernias in infants and children are *indirect*
  - They occur as a result of the failure of obliteration of the *processus vaginalis*.
  - Sac is adherent to the vas deferens
  - [Incomplete obliteration of *processus* may also lead to hydrocele.]
Etiology (2)

- Acquired Hernia ~ Direct or Indirect (Nyhus type 3)
  - Over age 25 the most common cause of inguinal hernia is attenuation or degeneration and fatty transformation of the aponeurotic tissues of the inguinal floor.
  - This can lead either to
    - **direct** weakness and bulging of the inguinal floor,
    - **indirect** hernia through a weak internal ring
    - or a combination of the two.
  - This is **not** work or activity related.
Relationship to “lifting” at work or other activity

- Lifting and straining make patients aware that they have a bulge.
- Lifting and straining do not usually cause the attenuation or degeneration of the inguinal floor, which is the underlying etiology of the hernia.
- Normal lifting does not cause recurrence.
- (Straining is not a good idea, whether you have a hernia or not.)
Important Things to Know

- Most adult indirect hernias are acquired.
- Indirect hernias have a peritoneal sac, hence can contain bowel (incarcerate, strangulate).
- Direct hernias contain preperitoneal fat, BUT large direct hernias can:
  - Have a peritoneal sac
  - Descend into the scrotum
  - Incarcerate, strangulate just like an indirect
1. = Indirect (anteromedial to cord)
2. = Sliding (lateral to cord)
3. = Direct (medial to cord and epigastric vessels)
4. = Lipoma of cord (inferolateral)
Important Things to Know (2)

- Incarcerated/strangulated hernia occurs far less frequently than most persons imagine.
- Lipomas (‘fatty tumors’) are common in the inguinal canal
  - Arise lateral/inferior to the cord, inside cremaster
  - Can be hard to differentiate from true hernia
- Clinical exam is not accurate in determining whether a hernia is direct or indirect.
Giant Scrotal Hernia (1/2 of small bowel + right colon)
Incarcerated Inguinal Hernia with Bowel Obstruction
More typical inguinal hernia
Watchful Waiting Study

- 720 men with minimally symptomatic hernias
- Randomized to watchful waiting or repair
- Followed 2-5 years
- Delaying surgical repair until symptoms increase is acceptable & safe
- Acute hernia incarcerations occur rarely
Femoral Hernia

- Develops in femoral canal, medial to femoral vein, below the inguinal ligament
- Occurs mainly in slender women, young or old
- Often has peritoneal sac
- Frequently presents with incarceration or strangulation
- Can cause bowel obstruction

Source: Undetermined
Incarcerated Femoral Hernia causing obstruction
Incarcerated Femoral Hernia
Incisional Hernia

- Can occur ANYWHERE an incision has been made, no matter how small.
Incisional Hernia

- Can develop in the original incision site because of dehiscence or failure of wound healing, or
- Can develop at the sites where sutures are passed through the tissue during closure (Swiss cheese-type hernia), or
- Both
Incarcerated incisional hernia

- Cannot be reduced.
- Tender
- What do you think is in it?
- How do you deduce this?
Causes of Incisional Hernia

- **Technical failure** or fascial dehiscence:
  - Sutures rip through, are placed improperly, or break
  - Weak tissue (“ppp”), tension, infection
  - Occurs within days or weeks after operation

- **FAILURE OF WOUND HEALING**
  - Most common cause
  - Seen 6-12 months after operation
Incisional Hernia

- Pressure on skin can cause ulceration
Incisional Hernia with Evisceration

- Note ulceration and spontaneous evisceration
- Cover with moist dressing.
- Take to operating room emergently for repair.
Incisional hernia with ‘peau d’orange’ (lymphedema)
Large panniculus

Small hernia
Interparietal hernia

- Very rare
- Between the layers of the abdominal wall
- Lateral to inguinal canal
Interparietal hernia

- Beneath external aponeurosis, coming through internal oblique muscle.
Left lower quadrant abdominal wall hernia outside inguinal canal containing sigmoid colon
Obturator Hernia

• Very rare
• Seen in elderly, emaciated patients
• Develops in obturator fossa
• Not visible or palpable on outside
• Can strangulate, cause bowel obstruction
Bowel obstruction from incarcerated obturator hernia
Obturator Hernia Causing Small Bowel Obstruction

Site of obstruction deep in pelvis
Infarcted small bowel from obturator hernia
Spigelian Hernia

- Very rare, difficult to diagnose.
- Develops at or near intersection of arcuate and semilunar lines, just lateral to rectus muscle.
- Has peritoneal sac; can cause of bowel obstruction
Spigelian Hernia
Laparoscopic view
Hydrocele

- Fluid collection in scrotum.
- Contained in peritoneal sac that may or may not communicate with peritoneal cavity via *processus vaginalis*.
- ‘Communicating’ hydrocele if peritoneal communication is present.
- Differentiated from true hernia by finding of normal (i.e., no bulge in) inguinal canal.
Giant hydrocele, asymptomatic
Lumbar Hernia

- Develops at Petit’s Triangle
- Between abdominal and back muscles
- Fascia in this region is thin
Diastasis recti

• Not a hernia!
• Seen when there is wide separation of rectus muscle in epigastrium
• Seen only when lying supine and raising one’s head.
• Not seen when one is standing.
Rare but interesting hernias:

- Richter: incarceration of a portion of the wall of the small bowel in a hernia.
- Littre: hernia containing a Meckel’s diverticulum.
- Mayer-Rokitansky-Kuster-Hauser syndrome: ovary and fallopian tube in inguinal canal, associate with incomplete genital development (absent uterus, etc).
- Amyand (1736): acute appendicitis in incarcerated inguinal hernia
- Unnamed: hernias containing normal appendix or ovary.