Case Report On Giant Incisional Hernia In Subcostal Incision

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Case Report On Giant Incisional Hernia In Subcostal Incision

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Abstract

Although rare but incisional hernia can be seen in patients with incisions other than median and paramedian incision. Presenting a case of incisional hernia in KOCHER'S incision who was operated for cholecystitis 8 months back. Incisional hernia generally develops in patients who have had wound infection, increased wound tension, improper closure techniques.

Introduction

Incisional hernia is a result of failure of proper closure of abdominal wall following surgery. Wound infection and dehiscence are the most important catastrophic event that can follow abdominal operation and incisional hernia may develop within months to years [1]. Incisional hernias are most commonly seen in patients with infraumbilical incision than with incision above umbilicus. The reported incidence varies widely between 0.5% to 13.9% [2]. Although exact incidence of incisional hernia through nonvertical incision has not been reported it ranges approximately to 1%. Though the incidence can be reduced by mass closure or by using non absorbable sutures.

The hernias associated with non vertical incision are associated with most complications like obstruction, incarceration or strangulation, if these are not treated early or left untreated. Recurrence in incisional hernia is also seen due to wound infection, seroma formation [3, 4], or patient condition like obesity, abdominal distention, violent cough or vomiting [5].

Case Report(s)

A middle aged normal built patient underwent Cholecystectomy 8 months ago, laparoscopy was attempted and converted eventually to open cholecystectomy, post operative period was uneventful, and patient was discharged 5 days after surgery there was no intraop complication and no post operative wound infection. Two months following surgery patient reported with fullness and a reducible swelling at the incision site. On exam swelling was reducible and cough impulse was present in the right hypochondrium gradually swelling increased in size to attain a size of 34X 30 cm in size extending upto 5th intercostal space. Patient was investigated and any precipitating factors for incisional hernia were evaluated.

Fig 1: Site and Size of Hernia
Fig 2: Examination in sitting position
Intraoperatively, skin scar was excised by elliptical incision, sac was adherent under the skin, sac was dissected all around the defect by deepening the incision till the oblique aponeurosis, strangely not much of fibrosis and no evidence of non-absorbable suture material was found. Flaps were mobilised to further define the defect, margins of the defect was quiet wide apart. plane was developed underneath external oblique aponeurosis, sac was plicated and Inlay mesh was placed 15*15 cm in size. Closed suction drain was kept.

Fig 3: Intraop picture after plication of the sac
Fig 4: After separation of the tissues and creation of plane
Fig 5: Post op picture
Post operative period was uneventful and patient was discharged after 7 days.
Illustrations

Illustration 1

Fig1: Site and Size of Hernia

Fig 2: Examination in sitting position

Fig 3: Intraop picture after plication of the sac
Fig 4: After separation of the tissues and creation of plane

Fig 5: Post op picture
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