

## A Rare Case from Practice: Strangulated Perineal Hernia

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### ABSTRACT

The article describes a rare case of strangulated perineal hernia in a woman. Brief anatomy of the pelvic floor. The clinical picture was characterized by intestinal obstruction. The patient underwent surgery after preliminary preoperative preparation and examination.

A perineal hernia in women is a protrusion that passes through urogenital septum (diaphragm urogenitales) or between the muscle fibers of the muscle that lifts the anus, or between it and other perineal muscles. The anatomical features of the structure of the perineum with the formation of depressions in the peritoneum can serve as predisposing factors in the formation of this hernia.

Rare forms of hernias include hernias of the xiphoid process, lateral hernias of the abdomen, lumbar, perineal. According to a statistical study of Russian surgeons, inguinal hernias account for 75 - 80%, femoral - 8%, umbilical - 4%, postoperative - 12% and rare forms of hernias - 1% of the total number of patients in a surgical hospital [6,7].

Congenital perineal hernia is rare. The absence of regression of the abdominal sac of the embryo is considered a predisposing factor to the formation of a hernia. Acquired perineal hernias are primary and secondary. Primarily acquired perineal hernias are caused by factors associated with increased intra-abdominal pressure. They are more common in women as a result of the wider female pelvis and weakening of the pelvic floor during pregnancy and childbirth [9].

Perineal hernia is a rare disease that occurs predominantly in women. This is due to the

peculiarities of the anatomical structure of the female pelvis and perineum [5].

The contents of the hernial sac are the bladder, internal genital organs. There are no standard methods of surgical treatment of perineal hernia [5]. The main approaches are transperitoneal and perineal. The presence of a developed network of blood vessels, nerve plexuses, and pelvic organs make this area a high-risk area during surgical interventions. The surgeon determines the closure of the hernia gate according to the detected changes.

Pathology is most often found in women. The female perineum is characterized by a special structure of the urogenital diaphragm and adjacent muscles. In men, the urogenital septum has a small opening through which the urethra passes, so the pathology is much less common and occurs in the back of the perineum. There are 3 types of hernia formations: anterior (Hernia perinaealis anterior) that comes out between mm. constrictor cunni, m. ischio-cavernosus, middle (Hernia perinaealis media), which coming out between mm. constrictor cunni, m. transverse perinei profundus back (Hernia perinaealis posterior) - comes out of the uterine-rectal recess of the peritoneum. Posterior hernial protrusions are usually larger than the anterior ones. Perineal hernial formations are also divided into complete and incomplete, with the latter remaining in the tissues of the perineum. The contents of perineal hernias in women are bladder, genitals. In posterior hernias, the intestines and omentum are most often located. [2,4].

Perineal hernias occur when damage to the muscles or fascia of the pelvic floor causes tissue to stretch or weaken. Injury, illness, pregnancy, and major pelvic surgery can cause this damage. The pelvic floor is a group of muscles that support the organs in the pelvic area, including the bladder and rectum. It also supports the prostate in men or the uterus and vagina in women.

Perineal hernias enter the perineum through defects in the pelvic diaphragm. This is one of the rarest forms of abdominal hernias, according to K.D. Toskin and V.V. Zhebrovsky (1990). N.S. Epifanov (1961) found in the world literature a description of only 64 clinical cases [1,5,7].

Patients complain of aching pain in the lower abdomen, a feeling of heaviness in the perineum, constipation, and difficulty urinating. Infringement of perineal hernias is observed as casuistry. Clinically, the infringement is acute, with symptoms of intoxication and intestinal obstruction. The contents of a hernia are usually the small intestine, but the hernial sac may contain an omentum or bladder. Recognition of perineal hernias is very difficult, especially in cases where the hernial protrusion is small and does not reach the subcutaneous tissue.

We present our own observation of a rare case of infringement of the perineal hernia with necrosis of the loop of the small intestine.

Patient D., 34 years old, was admitted by gravity to the emergency department of the Bukhara branch of RRCEM. Complained of cramping pain over the bosom, nausea, vomiting, general weakness. According to the patient, such complaints appeared about 3 days ago. She was examined by a gynecologist in the admission department: general condition of moderate severity. The skin is of normal color, dry, warm. Body temperature 37.3°C. From the anamnesis it is known that the patient has been using the IUD for several years. There are no respiratory disorders. Respiratory rate 17 per minute. Pulse 98 beats/min, satisfactory filling. Blood pressure 90/60 mm Hg. Art. The tongue is dry and clean. The abdomen is tense in all departments, painful in the womb. On percussion, tympanitis is determined, and on auscultation, weakened intestinal motility is heard. Symptoms of peritoneal irritation are weakly positive.

According to the ultrasound of the abdominal organs: the pancreas is not clearly visualized, pneumatosis is expressed, stones up to 12 mm in diameter are visualized in the gallbladder

cavity. In the Douglas space there is free fluid in the volume of about 150-200 ml, other pathological changes in the abdominal organs were not detected.

A culdocentesis was performed . The puncture yielded about 200 ml of serous-fibrinous fluid. The patient was suspected of intestinal obstruction and a survey radiography of the abdominal cavity was performed. X-ray shows multiple Kloiher's bowls in the left side of the abdominal cavity.

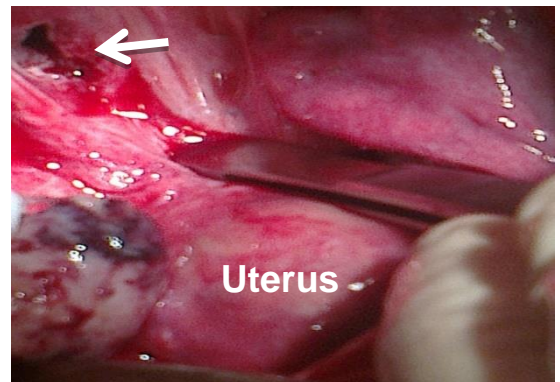
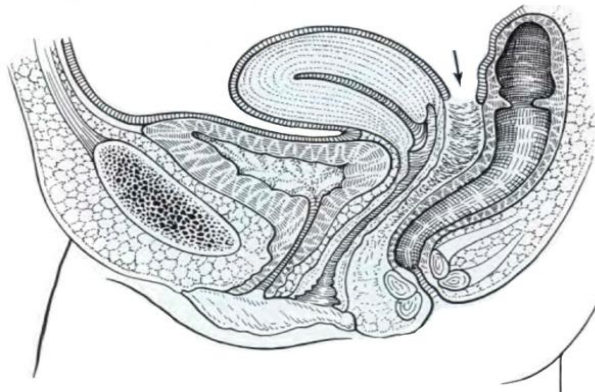
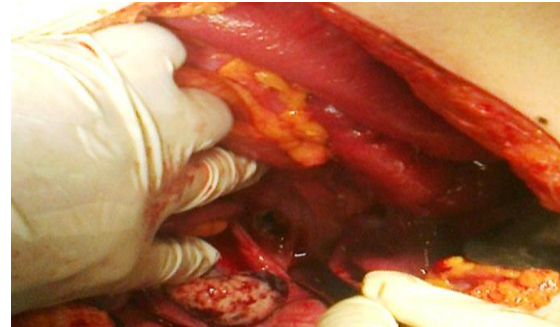
Taking into account the data of the anamnesis, clinical and radiological examination, the patient was diagnosed with: "Acute small bowel obstruction. Peritonitis". Despite the ongoing intensive conservative treatment (infusion, antibacterial, antispasmodic therapy, intestinal stimulation, cleansing enemas), the patient's condition progressively worsened, the Shetkin - Blumberg symptom is positive in all parts of the abdomen. The patient was recommended surgical treatment for health reasons, the patient agreed.

After 2 hours of preparation on May 4, 2012 at 20.20 the patient was operated on. Produced mid-median laparotomy. About 500-600 ml were found in the abdominal cavity. serous-purulent effusion, which is drained by electric suction . During the revision of the organs, loops of the small intestine overextended with gas and liquid contents with purulent-fibrinous plaque were found. The loop of the terminal small intestine was also found to be pinched in the gap between the iliococcygeal muscle and the levator ani muscle (forming a pinched posterior perineal hernia).

The hernial orifice was dissected and the strangulated loop of the small intestine was removed from the hernial sac into the abdominal cavity. The strangulated section of the intestine is black, there is no peristalsis, the pulsation of the mesenteric vessels is not detected. A 40 cm long necrotic portion of the small intestine was resected within intact tissues, followed by a side-to-side anastomosis.

The hernial defect was closed by suturing the surrounding muscles with interrupted sutures. Nasointestinal intubation was performed with a double-lumen silicone probe. Produced sanitation and drainage ( subhepatic space, side channels and pelvic cavity) of the abdominal cavity.

Postoperative diagnosis: Incarcerated posterior perineal hernia. Complication: acute small bowel obstruction. Gangrene of the small intestine. Diffuse purulent-fibrinous peritonitis, toxic phase.



**Rice. Hernial orifice of the posterior perineal hernia. (The arrow indicates the gap between the iliococcygeal muscle and the muscle that lifts the anus).**

The course of the postoperative period went smoothly. Oral nutrition of the patient started on the 3rd day after the operation. The function of the gastrointestinal tract was restored in full. Healing of postoperative wounds by primary intention. The patient was discharged in a satisfactory condition on the 9th day after the operation.

Thus, this clinical observation confirms the possibility of infringement of perineal hernias, the fact of which was previously considered casuistry.

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