



Irreductable Nonstrangulated Lumbar Hernia Mimicking Lipoma: A Case Report

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We submit a 45 year old woman presenting irreduction of sigmoid colon within a lumbar hernia. There was no large bowel obstruction or strangulation so; this entity was misdiagnosed as lipoma.

Key Words: Lumbar hernia, Sigmoid colon, Strangulation, Lipoma

Lipomla Karıştırılan Redükte Olmayan Boğulmamış Lomber Fıtık: Olgu Sunumu

Bu çalışmamızda, lomber bölgede lipom yanlış tanısıyla ameliyata alınan, redükte olmayan lomber fıtıklı 45 yaşında kadın hastamızı sunuyoruz. Olgumuzda fıtık kesesi sigmoid kolonu içeriyordu ve boğulma veya obstrüksiyon yoktu.

Anahtar Kelimeler: Lomber fıtık, Sigmoid kolon, Boğulma, Lipom

Lumbar hernias are rare defects in the posterolateral abdominal wall. The hernia may contain retroperitoneal fat, kidney, colon or even intraperitoneal structures such as small bowel, omentum, and stomach.¹ The site of herniation can be divided into the inferior lumbar triangle (Petit) and upper lumbar triangle (Grynfeltt).²

Approximately 300 lumbar hernias have been reported.³ Incarceration and strangulation are rare where small and large intestine are found in the sac.²

CASE

A 45 year old obese female patient presented with moderate pain and swelling in the right lumbar area for ten years. There was no history of previous surgery or injury. On physical examination there was a mass about 10 cm in diameter on the same area. It was soft, round and mobile. It didn't reduce in any position suggesting a lipoma of lumbar area. Ultrasonography (USG) findings were correlated with lipoma.

Patient was taken to the operating room with a diagnosis of lumbar lipoma by plastic surgeons (fig.1). During the dissection of the mass it was noticed that the mass was colon and it was injured from multiple sites (fig.2). A intraoperative general surgery consultation was claimed and general surgeons participated the operation. The multiple iatrogenic perforations on the sigmoid colon wall were repaired primarily. After the repair the bowel was reduced. During further exploration of the defect, a diagnosis of moderate-sized hernia originating through the right inferior lumbar triangle was confirmed. This orifice was repaired with on lay polypropylene mesh technique.

The patient's postoperative course was uneventful and he was discharged on postoperative day 8.

DISCUSSION

Lumbar hernia occurs either in the inferior (Petit) or superior (Grynfeltt) lumbar triangle. The inferior triangle is the unusual site. It is bounded by the posterior border of the external oblique muscle anteriorly, the anterior border of

the latissimus dorsi muscle posteriorly and the iliac crest inferiorly. The superior lumbar triangle may also be the site of these rare hernias. It is bounded by 12th rib superiorly, erector spinae medially and the internal abdominal oblique muscle anteriorly.

Figure 1. Pre-operative view



Figure 2. Incarcerated sigmoid colon from the left inferior lumbar triangle (petit)



Lumbar hernias are classified as congenital (%20) or acquired.^{2,4} The hernias are caused by several factors such as raised intraabdominal pressure, obesity, excessive weight loss, polio, old age and debilitating disease.^{5,6} They may be secondary to trauma or surgical procedures i.e. flank incision and infectious states such as cold abscesses.^{4,7} Obesity may be considered as predisposition factor in this case. They are twice on the left site than the right side. The higher position of the left kidney explains the predilection of the lumbar hernia on the left site.⁴ Patients are usually asymptomatic but may complain of low back pain. Feeling of weight or a dragging sensation may be the clinical manifestations.⁵ In our case, the hernia assumed large proportions before the

patient complains and eventually a soft, nonreducible swelling suggesting lipoma palpated in the flank.

The diagnosis is usually not difficult to establish although certain differential diagnosis has to be considered such as abscesses, hematoma and tumours.⁶ In the present case, hernia was incarcerated but not strangulated. It was misdiagnosed as lipoma clinically. There were no physical examination in favor of hernia such as reducibility of mass, cough impulse and increasing in size on straining. USG or abdominal CT scans are useful adjuncts in the diagnosis of lumbar hernias which is based on the finding of a defect in the abdominal wall, intraparietal sac, or contents in the sac.^{4,8} In our case, USG findings were correlated with lipoma so; patient did not refer to CT examinations.

Several techniques of reinforcement of the defect have been described including mesh repair, flap techniques,⁹ simple closure⁶ and laparoscopic repair.¹⁰ We preferred on lay mesh technique after primary closure of the defect because defect was not small and the tissues were poor. Even, some publishers claim that only primary closure is inadequate even if defect is small.⁸

In conclusion, sometimes USG couldn't allow correct diagnosis in lumbar hernia and, evaluation of a lumbar mass could be difficult to accurately and should include CT initially, and needle aspiration should be avoided since these hernias often maybe filled with bowel as in our case.

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