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UMBILICAL HERNIA WITH EVISCERATION. TWO CASES AND A REVIEW OF THE LITERATURE

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Abstract—Background: Evisceration of umbilical hernias is an uncommon occurrence whereby the hernial contents break through the skin overlying the sac and skin. Irrespective of cause, sudden evisceration of an umbilical hernia is associated with deterioration and a poor outcome. **Case Reports:** Our first case was a 42-year-old woman who presented with sudden outpouring of fluid from the umbilicus with omental evisceration. Further evaluation revealed hepatic decompensation caused by hepatitis C infection belonging to Child-Turcotte-Pugh class C. After stabilizing her hemodynamically, she underwent a partial omentectomy with primary repair of umbilical defect. The patient's postoperative course was challenging. She died of septicemia and acute renal failure after 5 days. Our second case was a 40-year-old man who suffered from alcohol-induced cirrhosis, presenting with omental evisceration, belonging to Child-Turcotte-Pugh class C. We performed a primary repair of the hernial defect with peritoneovenous shunting for his intractable ascites. Upper gastrointestinal endoscopy revealed grade I esophageal varices. The patient succumbed to acute variceal hemorrhage with acute renal failure 18 days later. **Why Should An Emergency Physician Be Aware of This?:** In an emergent setting with multiple factors influencing final surgical outcome, it is imperative that management be tailored for each patient. Those with severe encephalopathy or cardiovascular instability must be stabilized before surgical intervention. Central

venous and blood pressures need to be closely monitored during resuscitation, as fervent fluid administration may predispose to variceal hemorrhage. It may be prudent to follow the principle of hypotensive resuscitation as in acute trauma cases. © 2018 Elsevier Inc. All rights reserved.

Keywords—ascites; eviscerated hernia; evisceration; hepatic encephalopathy; umbilical hernia; ventral hernia

INTRODUCTION

Umbilical hernias are a routine presentation in any general surgical clinic. Acquired umbilical hernias occur through a weakening of the cicatricial tissue at the umbilical ring. Most cases undergo surgery on an elective basis; there is an emphasis on eliminating causes of increased intra-abdominal tension that may lead to recurrence. Emergency surgeries are performed in the presence of complications such as obstruction, strangulation, and rarely evisceration.

Evisceration of umbilical hernias is an uncommon occurrence whereby the hernial contents break through the skin overlying the sac and come into direct contact with the external environment. Evisceration may occur spontaneously after gradual worsening of the hernia and thinning of the wall or it may be abrupt as when caused by trauma or sudden straining (1). We report 2 cases of

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eviscerated umbilical hernias in patients with hepatic decompensation who were operated upon with poor outcome.

CASE REPORTS

Case 1

A 42-year-old woman presented to the emergency department in a disoriented state with complaint of copious watery discharge from the umbilicus. On examination, the patient was found to be dehydrated with tachycardia, hypotension, and bilateral pitting edema. She was tachypneic with pulse oximetry of 95% oxygen on room air. Her abdomen appeared distended with generalized tenderness without guarding or rigidity, with a 10- × 5- × 4-cm segment of omentum eviscerated at the umbilicus (Figure 1). The omentum appeared dry and congested with few areas of pinpoint hemorrhage and was surrounded by deeply congested, stretched skin. Any manipulation of the omentum resulted in outpouring of straw-colored fluid from the opposite side. Despite continuing an ascitic fluid leak, the patient's abdomen still demonstrated shifting dullness without perceptible fluid thrill. Internal jugular venous access was gained which revealed central venous pressure (CVP) of 4 to 6 cm of water.

Family members mentioned a history of a gradual increase in abdominal girth over the past few months with sudden outpouring of large amounts of fluid from the umbilicus a few hours earlier. The spontaneous fluid leak ceased 1 h before presentation with the appearance of a



Figure 1. Eviscerated omentum at an edematous, stretched umbilicus with ascitic fluid seeping through the skin defect.

long, irregular, pinkish structure at the umbilicus. There was no history of any ulceration at the umbilicus.

The patient had a history of admissions for similar abdominal distension with episodes of disorientation and hallucinations over the past few years. Paracentesis was employed on multiple occasions, the most frequent of which was 5 months before presentation; the patient was managed conservatively with improvement in cognition after each episode. Current medications included spironolactone, lactulose, and low-dose furosemide.

A hematologic evaluation revealed an adequate hemoglobin level of 10.8 g/dL, total leukocyte count of 22,500 cells/mm³, and a platelet count of 145,000 cells/mm³. Biochemical tests revealed acute renal failure (serum creatinine 3 mg/dL, urea 86 mg/dL) and hepatic dysfunction (serum albumin 2.9 g/dL, total serum bilirubin 1.5 mg/dL, direct bilirubin 0.84 mg/dL, serum glutamic oxaloacetic transaminase 83 U/L, serum glutamic pyruvate transaminase 95 U/L, International Normalized Ratio 1.6). Hypoalbuminemia of 2 g/dL was indicative of poor nutritional status of the patient. Notably, serum ammonia levels were elevated at 152 μg/dL and arterial blood gas analysis revealed a partially compensated metabolic acidosis. Ultrasonography demonstrated liver cirrhosis with gross ascites with serology revealing hepatitis C as its cause. The patient was Child-Turcotte-Pugh class C.

Fluid resuscitation with crystalloids was initiated and later titrated according to central venous pressure and urine output. The disoriented state of the patient along with 1 episode of vomiting during the preliminary evaluation prompted nasogastric decompression. The eviscerated hernia was wrapped in a warm normal saline dressing.

The patient was taken for surgery under general anesthesia after adequate fluid resuscitation. The umbilical skin was edematous and stretched. A narrow elliptical incision around the defect revealed a 1 × 1.5 cm defect at the umbilicus with congested omentum herniating through it. The defect was increased in size starting at a virgin point 5 mm superior to it, with drainage of abundant ascitic fluid. Omentum proximal to that wedged at the defect appeared normal, while the distal segment was congested with superficial slough. The umbilical defect was primarily closed with continuous polypropylene suture and a subcutaneous suction drain was placed. We opted out of mesh placement in view of high risk of its infection.

The patient's hepatic encephalopathy remained stagnant postoperatively with worsening of ascites along with septicemia that failed to respond to antibiotics. Septicemia-induced acute renal injury with hyperkalemia (6.1 mEq/L) further complicated fluid management in a patient unfit for enteral feeding. The patient died on postoperative day 5.

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