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Case Reports 2020- Foramen of Winslow Hernia- Maria Julia Corbetta Machado- John Hunter Hospital

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Background

Small bowel obstruction is a common cause of surgical admission, a minority (0.08%) of which is caused by Foramen of Winslow hernia (FOWH). This entity can be particularly difficult to diagnose, and have been associated with high mortality rates in former years. With the development of accessible computer tomography (CT) earlier diagnosis can be achieved, resulting in better outcomes. The conjunction of FOWH and Mackle's diverticulum has been reported in the literature, however as a rarity. In this case report, a 76-year-old gentleman presented to our emergency department with features of small bowel obstruction (SBO) and found to have a Meckel's diverticulum herniating through FOW as a cause of his SBO.

Case Report

A 76 yrs. patient presented to the emergency department with a one-day history of obstructive symptoms associated with central abdominal pain. His medical background consisted of ischaemic heart disease (previous Coronary Artery Bypass Graft surgery), dyslipidemia, melanoma excision, open hernia repair and open appendectomy. An Abdominal CT was performed, and it showed a FOWH. He was then taken to theatre for a laparoscopic reduction of small bowel obstruction. Intraoperatively, a Meckel's diverticulum herniated through the Epiploic foramen causing the SBO was identified. Decision was made to perform a diverticulectomy; in a tangential fashion. This was performed using a 60mm laparoscopic GIA stapler. The patient had an uneventful postoperative recovery, being discharged from hospital D4 post procedure. The histopathology was reviewed and it confirmed normal histology without ectopic tissues.

Herniation through the foramen of Winslow is an uncommon condition that can prompt a deferred finding and treatment with a high death rate. In most revealed cases, patients present to the crisis office with indications recommending intestinal deterrent or with unexpected and extreme torment in the upper mid-region. Side effects are vague. Clinical determination might be troublesome or even missed. The across the board accessibility of cross-sectional imaging can improve the level of right preoperative conclusion. We report an instance of a caecal and right colic herniation through the foramen of Winslow discovered by chance on stomach processed tomography in a patient giving gentle epigastric agony. The rate of preoperative diagnosis has been reported to be <10% of the intraoperatively confirmed cases. A delay in diagnosis and treatment is often observed and may be responsible for the high mortality rate of up to 49% associated with this hernia type. Internal hernia is often revealed by intestinal obstruction associated with non-viable bowel at the time of operation.

Foramen of Winslow hernia can be defined as peculiar variant of internal abdominal hernia, since it is a normal peritoneal orifice kept closed by normal intra-abdominal pressure that may be permeated by the intra-abdominal viscera.

There are multiple anatomical abnormalities reported as possible predisposing factors for a visceral herniation through this foramen: (i) abnormally enlarged foramen; (ii) the presence of an unusually long small-bowel mesentery or persistence of the ascending mesocolon; (iii) an elongated right hepatic lobe, which could be directing the mobile intestinal loop into the foramen; (iv) a lack of fusion between caecum or ascending colon to the parietal peritoneum; (v) a defect in the gastrohepatic ligament, (vi) incomplete intestinal rotations or malrotation.

Since the first report in 1834 by Blandin in autopsies, <200 cases of foramen of Winslow hernia have been reported in the medical literature.

Symptoms are usually related to bowel obstruction. The typical presentation is an acute severe mid-epigastric pain associated with nausea and vomiting. The severity of the pain is related to the presence of bowel strangulation with subsequent necrosis. In some very particular cases, the internal hernia through the Winslow hiatus is revealed by an obstructive jaundice due to direct compression of the hepatic pedicle.

The key to diagnosis relies on prompt radiologic studies and the CT scan is nowadays considered the technique of choice. Various, more or less specific findings have been reported, such as an air-fluid collection in the lesser sac or signs of small bowel obstruction associated with the presence of mesenteric vessels stretching anterior to the inferior vena cava and posterior to the portal vein; the absence of the ascending colon in the right gutter and an antero-lateral displacement of the stomach.

The treatment invariably requires urgent surgery, and even if symptoms are limited as in our case, it should be considered in order to assess intestinal viability because of the risk of intestinal strangulation.

Treatment is based on careful inspection with subsequent hernial reduction that is frequently possible with simple and

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gentle traction. Occasionally, this can be difficult; in these situations the gastrocolic or gastrohepatic ligaments must be opened or, alternatively, a wide Kocher manoeuvre performed. In the case of massive colonic dilatation a colotomy for decompression with a suction device can be useful.