Internal hernias are visceral protrusions through the peritoneum or mesentery into an abdominal cavity compartment. Hernial orifices are either pre-extant anatomical structures or abnormal defects secondary to surgery, trauma, inflammation, and circulation disorders (1-4). Their diagnosis is challenging since clinical and imaging findings are usually unclear (1,5). We report a case of this rare condition in order to assess its diagnostic approach and need for early management.

A 62-year-old male patient visited the emergency room because of severe abdominal pain in the hypogastric region with no other associated manifestations. His surgical history included radical cystectomy for bladder carcinoma with “vescica ileale padovana-type” reconstruction (detubed, continent ileal orthotopic neobladder) 10 years ago. Physical examination reveals severe abdominal tenderness in the hypogastric region without vesical globe or clear peritoneal irritation signs. Test results included mild leukocytosis with neutrophilia not associated with increased acute phase reactants or urine sediment findings. Bladder catheterization was straightforward and 200 cc of clear urine were obtained; pain persisted, which prompted an abdominopelvic CT scan. The patient had emergency surgery with exploratory laparotomy, which showed an internal pelvic hernia posterior to the neobladder with incarcerated small bowel loops, which were eventually reduced and fully recovered from intestinal ischemia, with closure of the hernial defect.

Internal hernia represents a rare cause of intestinal obstruction and ischemia with an incidence of 0.2-0.9%. It may be congenital or acquired, the latter type resulting from a number of origins including surgery, as in our patient (1-3). Imaging-related diagnosis is challenging, but suggestive signs may show up (4,5). An appropriate preoperative diagnosis should indicate early surgery to avoid intestinal necrosis and resection.

REFERENCES