

## A RARE CASE OF “THE LITTLE OLD LADY’S HERNIA” - A CASE REPORT

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### Abstract

Hernias among the elderly population present unique challenges in diagnosis and management. Among these, the "Little Old Lady's Hernia" stands out as a rare yet significant clinical entity. This case study and review aim to shed light on this atypical presentation, characterized by subtle symptoms often masked by comorbidities or attributed to age-related changes. The "Little Old Lady's Hernia" refers to a femoral hernia commonly seen in elderly women, manifesting as a protrusion in the groin area. Its presentation tends to be subtle, making diagnosis challenging and delayed, resulting in potential complications. This paper examines the clinical features, diagnostic modalities, and therapeutic approaches to this distinct hernia subtype, emphasizing the importance of early recognition and tailored interventions. Through a retrospective analysis of reported cases and a detailed examination of a recent clinical encounter, we highlight key diagnostic clues and therapeutic strategies. Emphasis is placed on the necessity of a high index of suspicion, thorough physical examination, and appropriate imaging techniques for accurate diagnosis. Additionally, we discuss the surgical considerations and outcomes in managing "The Little Old Lady's Hernia" to prevent complications and ensure optimal patient care. Understanding the nuances of this hernia variant is crucial for healthcare practitioners to provide timely and effective interventions, ultimately improving outcomes for elderly patients affected by this condition.

## INTRODUCTION

An obturator hernia occurs when an organ or tissue protrudes through the obturator canal, either intraperitoneally or extra-peritoneally. Despite being a rare form of abdominal wall hernia, it carries a significant mortality risk, reaching as high as 40%. The predominant manifestation is bowel obstruction, and the increased mortality is attributed to complications like strangulation, bowel necrosis, and bacterial peritonitis. Accounting for 0.5-1.4% of all hernias, it is more commonly observed in elderly females. Here, we present a case necessitating emergency surgery due to its unusual presentation with nonspecific symptoms and the challenge of diagnosing it preoperatively.

## CASE PRESENTATION

A 67 year aged female came to emergency with complaints of abdomen distension, constipation, vomiting for 5 days. She is a known case of hypertension and had a past surgical history of vaginal hysterectomy before 25 years. On examination, she was conscious, oriented, her vitals were stable. Abdomen was distended with increased bowel sound. Other systemic examination was normal Her per rectal examination shows absent faecal staining. On ryle's tube aspiration around 2litre of faeculent material was collected. Her blood investigations are within normal limits. Her CT abdomen shows grossly distended stomach with significantly dilated bowel loop with multiple air fluid level. Level of obstruction is ileum with abrupt narrowing in the transition zone with no mass. We suspect band/adhesions as a cause of obstruction due

to prior history of surgery. Emergency laparotomy was planned.

On exploration, it is found that ileum was getting herniated through the left obturator canal. After reducing the contents, it is found that bowel vascularity was compromised hence resection of ileum and end to end ileo-ileal anastomosis was done. Then the defect was closed using prolene mesh plug. She was treated with Broad spectrum antibiotics, rational nutritional support and careful monitoring of vital organs was done. Her post op period was uneventful. She was discharged after 15 days in a hale and hearty state.

## DISCUSSION

Obturator foremen is formed by union of ischium and pubis. This foramen is almost closed by obturator membrane except superolaterally which is Obturator canal. Through this canal, obturator nerve, artery, vein exit and enters thigh. Weakening of the obturator membrane may cause the canal to widen and a hernia sac to form, which may entrap and strangle the intestine. It typically affects elderly, multiparous, and underweight women, earning the moniker "little old lady's hernia". It accounts for 0.5-1.4% of all hernias.<sup>[1]</sup> Due to their wider pelvis, more triangular obturator canal opening, and larger transverse diameter, females experience it nine times more frequently than males do. Another frequent risk factor seen in connection is rapid weight loss accompanied by expanded space in the obturator canal. The extra room seems to make it easier for the bowel to enter, which raises the possibility of trapping. As mentioned in a case report by Carter, Taylor et al,<sup>[2]</sup> The additional risk factors are ascites, chronic constipation, and chronic obstructive pulmonary disease. Because the signs and symptoms of obturator hernia are sometimes vague, diagnosing the condition can be difficult. Acute intestinal obstruction is the primary clinical symptom. Like mentioned in case report of Li Han et al,<sup>[3]</sup> Sometimes patients may tell the history of pain on the antero-medial portion of the thigh due to obturator nerve compression. It's known as the Howships-Romberg sign the pain is relieved by thigh flexion. As in case report of Ibrahim Aydin et al,<sup>[4]</sup> Rarely patient also has The Hannington-Kiff sign is a clinical sign in which there is an absent adductor reflex in the thigh in the presence of a positive patellar reflex. It is also due to compression of the obturator nerve. A CT abdomen and pelvis, preferably with contrast, is used to make the diagnosis. On CT scans, a circular, teardrop-shaped, or short tubular hernia sac may be visible. Imaging may reveal a characteristic "beak-like" alteration when the intestinal canal herniates into the obturator tube, causing the obturator and internal muscles to abruptly narrow.<sup>[3]</sup> Although CT abdomen is a valuable tool, sometimes richter type of hernia will not be able to made out. Obturator hernia is only treated surgically. Like mentioned in Barbosa,

Bruno Rafael da Silva et al,<sup>[5]</sup> There are a variety of operative approaches including inguinal, retropubic and trans peritoneal approach. Diagnosis is rarely made preoperatively, so laparotomies are frequently performed. The complete trendelenberg position is used. After the content is reduced, the defect is either primarily sutured or closed with a mesh plug or a broad ligament plug. Laparoscopic TAPP is also an option. If the diagnosis is made pre operatively , open or laparoscopic posterior approach is preferable. This method allows for direct access to the hernia. Any pre-peritoneal fat within the obturator canal is reduced once the hernia sac and contents are minimised. The obturator foramen is opened posterior to the nerve and vessels if necessary. To assist fat pad reduction, the obturator nerve can be gently massaged with a blunt nerve hook. The obturator foramen is repaired with prosthetic mesh while taking care not to injure the obturator nerve or arteries. Most of the surgeons prefer closing the defect with simple interrupted non tension sutures.<sup>[6]</sup>

## CONCLUSION

The clinical landscape surrounding obturator hernias, although infrequent, demands heightened vigilance due to the potential for substantial morbidity and mortality. Thorough comprehension and swift recognition of the constellation of clinical signs and symptoms associated with this hernia variant are pivotal. The nuanced presentation, often masked by nonspecific groin discomfort and exacerbated by movements involving the hip joint, underscores the need for meticulous clinical assessment. Furthermore, the critical role of computed tomography (CT) imaging in expediting diagnosis cannot be overstated. Early performance and adept interpretation of CT scans serve as linchpins in the timely identification of obturator hernias, facilitating precise localization and evaluation of herniated contents. This accelerates the commencement of tailored interventions, averting deleterious consequences associated with delays in diagnosis. Delays in diagnosing obturator hernias pose an ominous risk, potentially culminating in intestinal necrosis, rupture, and subsequent peritonitis, thereby significantly amplifying the peril of mortality. However, prompt diagnosis serves as a pivotal determinant in mitigating the extent of ischemia or necrosis, substantially diminishing the looming threat of bowel perforation and its dire complications. In essence, a comprehensive understanding of obturator hernias, coupled with a heightened index of suspicion, robust clinical evaluation, and judicious utilization of imaging modalities like CT, is indispensable. Timely diagnosis not only circumvents potential catastrophic outcomes but also paves the way for expedited and tailored therapeutic strategies, thereby optimizing patient outcomes and reducing the burden of morbidity and mortality

associated with this rare yet clinically formidable condition.

## REFERENCES

1. Ghimire, S., Dhakal, S. K. S., Rai, P., & Rai, N. (2022). Early CT Ameliorates the Diagnostic Dilemma of "Little Old Lady's Hernia": A Case Report. *JNMA: Journal of the Nepal Medical Association*, 60(252), 735.
2. Valente, T., Ferreira, N., Ferreira, G., Figueiredo, A., Bárbara, P., Marinho, R., ... & Santos, M. C. (2022). Little old lady's hernia: a case of strangulated obturator hernia in a 88-year-old woman. *International Surgery Journal*, 9(12), 2045-2047.
3. Gilbert, J. D., & Byard, R. W. (2019). Obturator hernia and the elderly. *Forensic Science, Medicine and Pathology*, 15, 491-493.
4. Carter, T., Ballard, D. H., Bhargava, P., & Samra, N. S. (2017). Obturator hernia, 'the little old lady hernia'. *J La State Med Soc*, 169(169), 96-8.
5. Bohara, S., Karki, S., Gautam, A., Regmi, B. U., Rimal, S., Khadka, L., ... & Rawal, S. B. (2023). Obturator hernia (the little old lady's hernia) diagnosed via computed tomography: a case report. *Annals of Medicine and Surgery*, 85(4), 1282.
6. Mercado, M., Diab, J., & Loi, K. (2021). A delayed diagnosis of obturator hernia hoodwinked by previous laparoscopic inguinal hernia repair. *Journal of Surgical Case Reports*, 2021(9), rjab407.