

Three's Company – Complex Ventral Hernia Requiring Medical Management

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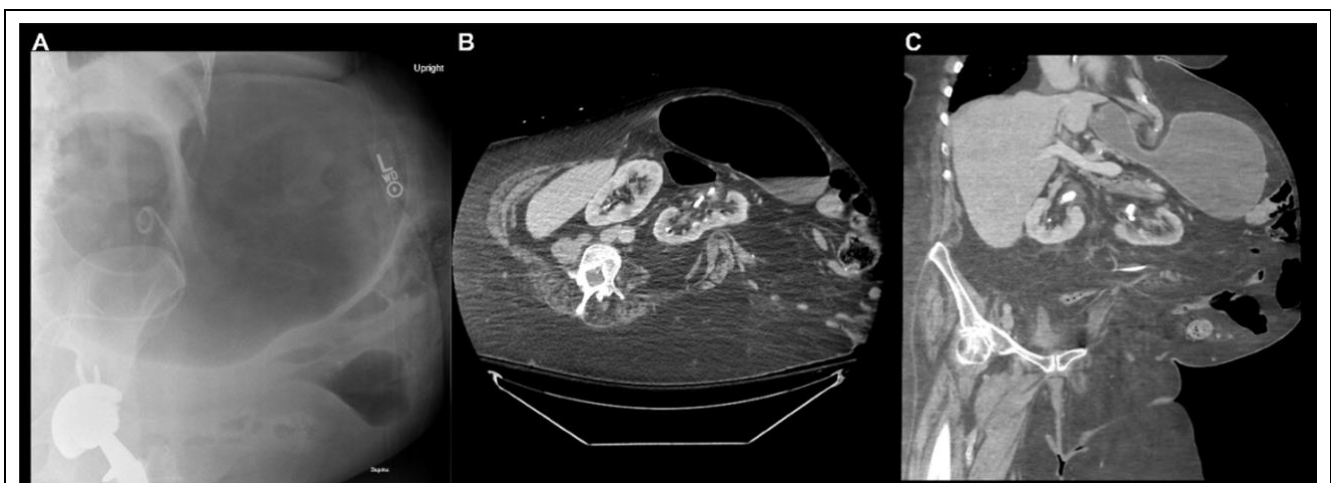


Figure 1: (A) Abdominal radiograph revealing marked gaseous distension overlying the left hemiabdomen. Axial (B) and coronal (C) views of a CT of the abdomen showing a complex ventral hernia with herniation of the stomach, small intestine, and large intestine.

Clinical Image

Abstract

Complex ventral hernias are described as large abdominal wall hernias with a width greater than or equal to 10cm. Traditionally, complex ventral hernias were treated with surgical intervention. However, in recent years, there has been a shift towards using a more multimodal approach including monitoring patient symptomatology and providing medical management.

Keywords: Hernia; Complex ventral hernia; Nausea; Vomiting; Non-surgical management; Medical management

Description

A 79-year-old female presented to the hospital for staghorn calculi surgery and developed nausea, vomiting, and worsening intake by mouth post-procedure. Patient's nausea was initially thought to be anesthesia related and anti-emetics were prescribed as initial therapy. On physical exam, a left lower abdominal wall hernia was noticed. An abdominal radiograph showed marked gaseous distension of the stomach concerning for gastric outlet obstruction (Figure 1A). A CT of the abdomen and pelvis showed the body of the stomach herniating through a large left anterior abdominal wall defect with much of the small bowel and colon within the hernia sac (Figure 1B, C). Endoscopy confirmed that the major portion of the stomach body was herniated into the abdominal wall hernia sac. There was no gastric outlet obstruction identified in the setting of large ventral hernia or evidence of bowel obstruction. The patient's symptoms self-resolved and she was able to tolerate food with regular bowel movements. Although this was a complex case of a ventral hernia that contained parts of the stomach, small intestine, and large intestine, the patient was only experiencing mild symptoms of nausea and vomiting, and no surgical intervention was performed. This case is a stark example of unusual and complex imaging findings juxtaposed to minimal and self-remitting symptoms that ultimately did not require invasive surgery. Instead, proper symptom and medical management allowed our patient to be safely discharged with close outpatient follow up care.