Clinics in Mother and Child Health

Maxime et al., Clinics Mother Child Health 2018, 15:3
DOI: 10.4172/2090-7214.1000299

Case Report Open Access

Perineal Hernia in a One Month Child: A Case Report

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Received date August 23, 2018; **Accepted date:** September 05, 2018; **Published date:** September 10, 2018

Abstract

Perineal hernia (PH) is the protrusion into the perineum of intraperitoneal or extraperitoneal contents through a congenital or acquired defect of the pelvic diaphragm [1]. They are classified as primary and secondary (postoperative) [2]. Primary PH can be congenital or acquired. PH are very rare conditions and even more so within paediatric population. The treatment of PH is surgical [3,4]. Many approaches and techniques of treatment were described in the literature. Among the cases described in the literature a few cases of children has been reported. In this report, we present a case of PH in a male child first described in Cote d'Ivoire.

Case Report

A one-month-old male infant received in consultation for a mass of the right buttock. He was born after a normal pregnancy and delivery with a birth weight of 3,000 g. This mass was found by the parents after fourteen days of life and occurring during crying. On physical examination, the infant had a good general impression. There was a mass of the right buttock, soft, painless, impulsive at the moment of tears and cries and reducible (Figure 1). The skin next to the mass was normal. There was also a painless scrotal swelling. Elsewhere, examination of other devices was normal. An ultrasound found a hernial sac in the right buttock containing digestive loops. This has been confirmed by the CT scan of the pelvis. The diagnosis of PH was retained. The hernia cure was performed at the age of four months. The approach was posterior (perineal). The patient was in a gynecological position. During the operation, a hernia sac containing digestive loops: the sigmoid and part of the rectum were identified (Figure 2). After reduction of the loops, the base of the hernia sac was ligated with the Vicryl® 2/0. Then the muscular planes were rapproched with interrupted 2/0 Vicryl® sutures to close the defect. Postoperative recovery was uneventful. He was discharged on the fourth postoperative day. After ten months, clinical investigation showed that the repair was good (Figure 3).

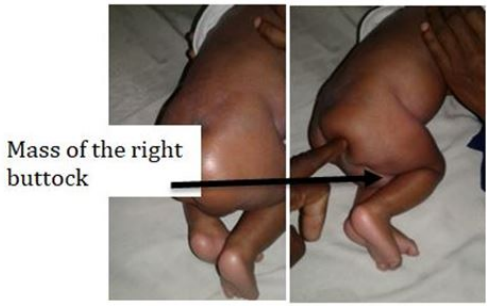

Figure 1: A reducible mass of the right buttock.

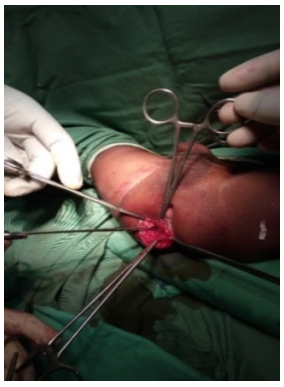

Figure 2: Perineal dissection to isolate and recognize hernia sac.

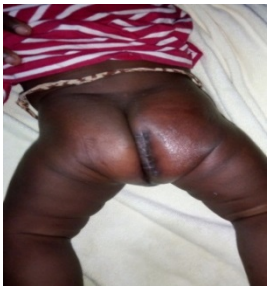

Figure 3: Ten months post-operative. The hernia repair is intact.

Discussion

PH were described for the first time in 1743 by Garangeort and are extremely rare [1,5]. The rarity of this condition is attested to by the paucity of studies reporting its occurrence and management [3].

Perineal hernias may occur anteriorly or posteriorly to the superficial transverse perineal muscles [1]. Anterior perineal hernias (which have never been reported in males) emerge anterior to the transverse perineal muscles and often present as a mass in the labia [3]. In posterior perineal hernias, the muscular defect lies posterior to the transverse perineal muscle, usually between the rectum and the ischial tuberosity [3]. In females, the defect is through the levator ani muscles or between the levator ani and coccygeus muscles [3]. In males, posterior perineal hernias may appear in the ischiorectal fossa or perineum, just lateral to the median raphe [3], as in our patient.

The diagnosis of perineal hernias is based on the clinical presentation and the technical investigation result. This diagnosis should be done at the birth during the new-born check. If this new-born check is missed, it could explain a delayed diagnosis as in our case. The clinical presentation consists of a mass in the buttoks which increases in size when the abdominal pressure increases either during coughing or when the baby cries as in our patient. The swelling is generally soft and reducible. This presentation is usually uncomplicated as in our patient. The hernia is rarely incacerated because of the wide neck and the relatively elastic tissue surrounding it.

Technical investigation which can help to confirm diagnosis of perineal hernia are: herniography [6], sonography [7], computed tomography (CT) [8], magnetic resonance (MR) tomography [9,10]. In our case we used sonography and CT to prove the diagnosis. They showed the hernia sac and its content.

Many surgical approaches have been described for the treatment of perineal hernias. Perineal approaches are described by So et al. and Martin et al. as an adequate therapy [11,12]. Some authors used transabdominal approach in most cases [13,14]. The combined abdomino-perineal approach is preferred by others [15,16]. These procedures can be performed either open or laparoscopically [17,18]. The laparoscopic repair has the advantage to be associated with rapid recovery and minimal complications [17]. To repair the pelvic defect different technique has been described. Some authors used direct suture of the muscular defect with good outcomes. Other authors used synthetic meshes or own tissues such as muscular grafts, peritoneal graft uterus and even bladder to close the pelvic defect [15,16,19-22]. Recently, biological meshes have been described as an alternative for repairing perineal hernia following an extra levator APR [23].

In paediatric population, many studies' outcomes showed that the perineal approach with primary closure in the chirurgical treatment of perineal hernias is associated with good result [3,24-28]. In our case we used direct suture to close the defect with absorbable suture after ligating the base of the hernia sac. Our outcome was excellent ten mounths after operation and no recurrence was seen.

Conclusion

Perineal hernias are rare conditions in paediatric population. The diagnosis is clinical and confirmed by technical investigations. The perineal approach with direct closure seems to be a best way of management of infantile perineal hernias.

Declaration of Interest

None.

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