



## Repair of a Primary Perineal Hernia

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### Abstract

Pelvic floor hernia known as perineal hernia is a hernia involving the perineum (pelvic floor). It includes sciatic, obturator, paravesical and perineal. The hernia may contain fluid, fat, any part of the intestine, the rectum, or the bladder. A perineal hernia may or may not cause a visible bulging or swelling under the skin to one side or both sides of the anus. Occasional may cause bowel obstructions. Surgical repair can be performed *via* open transabdominal and transperineal or combined abdominoperineal repair. In our case study, patient revealed at gluteal enlargement while standing, reduces when supine. Both transperineal and transabdominal repair have been performed on this patient.

**Keywords:** Perineal Hernia; Pelvic; Transabdominal repair

### Introduction

Pelvic floor hernias are not common [1,2]. It is a weakness of the endopelvic fascia and musculature lead to herniation of the intra-abdominal and pelvic organs, such as small bowel, colon, and bladder [3]. In most instances, a perineal hernia is associated with increased intra-abdominal pressure. It is more common in females because the broader pelvic inlet and the stresses of pregnancy, labor, and delivery [4-6]. Though the most common cause of pelvic floor hernia is childbirth, obesity and chronic coughing are conditions that can cause damage to the muscles tissues which prevent prolapse [5]. Pulmonary lung diseases such as bronchitis as well as constipation can also contribute to perineal hernias.

### Case Presentation

A 61-year-old woman presented with a history of asymmetrical buttocks, swelling of the right buttocks, and pain (Figure 1). There were no prior history of trauma or pelvic surgery; only history of cesarean section. Upon examination reveals swelling of right buttocks, not palpable when supine. Following MRI of the pelvis with and without IV contrast reveals severe thinning, bulging and eventration of the right puborectalis muscle with herniation of fat through this defect (Figure 2). And downsloping of the right iliococcygeus muscle.

Since the hernia was symptomatic, the patient wanted to attempt repair from the perineal approach since she had previous abdominal surgery.

A small incisional was made in the infragluteal fold right side; The hernia was identified, fat and content reduced, the hernia was reduced and repair in layers with 1.0 vicryl in figure of 8 interrupted fashion. The skin was then re-approximated with vicryl and monocryl followed by a compression dressing. The patient's postoperative course was uneventful and she was discharged on day 1.

Four months post-surgery the patient re-prolapsed and presented with symptoms of nausea when eating and evidence of incarceration but reducible hernia. At this point, it was decided to proceed with an open pelvic floor hernia repair with mesh. Since she had a lower midline scar in the past, the patient wanted an open operation with revision of her surgical scar as she had a wide keloid from her previous surgery. Intraoperatively, there was a tremendous amount of adhesions. A large fibroid uterus was also noted (Figure 3).

The hernia defect was previously noted on the patient's right side. A 7.5 cm × 4 cm piece of Gore dual mesh was cut to size and placed and aligned over the defect. A laparoscopic tacker was used to secure the mesh over the defect. And the overlying skin was closed (Figure 4).

At 2 months follow up the patient was doing well and without recurrence.

### Discussion

Perineal hernias may be classified into two categories, primary such as congenital or acquired

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**Figure 1:** Physical exam finding of asymmetric buttocks in the standing position.



**Figure 2:** MRI Pelvis showing perineal hernia.



**Figure 3:** A large fibroid uterus.

or secondary such as postoperative [7-9]. Perineal hernia is a weakening or a complete failure of the muscular diaphragm of the pelvis. Normally the pelvic muscles are for support and to keep the abdominal content from intruding into the rectum. Perineal hernias can also occur after major pelvic floor surgery however they are usually not very commonly seen complications and when it does occur, it is usually asymptomatic.

According to Aboian, in a retrospective study that was done in 2006, it showed that a frequent rate of symptomatic postoperative perineal hernias about 0.34% was noted in those who were more commonly associated with cancer operations [10]. However, there are other risk factors that can cause perineal hernia such as previous pelvic floor dysfunction, pelvic floor surgery, smoking, female gender, and chemoradiation therapy [10-12]. During pregnancy, there's an increase in pressure on the pelvic region due to the growth of the fetus and also the pelvic floor from hormone-mediated physiological changes as well to accommodate the pressure from the growing



**Figure 4:** Finished trans-perineal repair.

fetus. The intra-abdominal pressure during the pregnancy can cause the pelvic floor to be weakened and also as one ages the pelvic floor muscle also weakens. The patient described in this case has been reported as female gender and has a history of being pregnant and having cesarean section.

Surgical repair is recommended if the patient is symptomatic. This can result in pain, discomfort, skin erosion over the herniated sac or even obstructions. There have been many techniques reported in the literature. They include transperineal, transabdominal and the combined abdominoperineal approach. In our case, the hernia was too big to have it repaired primary resulting in failure. An abdominal approach with mesh allow for a more durable result.

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