Spigelian Hernia in a 14-Year-Old Girl: A Case Report and Review of the Literature

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Introduction

Spigelian hernia (SH) is a surgical rarity in children, which occurs through slit-like defects in the anterior abdominal wall adjacent to the semilunar line, the convexity lateral line which joins the nine ribs to the pubic tubercle and signs the limit between the muscular and aponeurotic portion of transversus abdominis muscle. As there are no specific symptoms and signs, the diagnosis is difficult, especially in children. We report a case of SH that comes to our observation: a 14-year-old girl presented recurrent abdominal pain associated to intermittent palpable mass in the paraumbilical region. Starting from our case report, we review the literature of pediatric SH from 2000 to 2013 and we describe the anatomy, etiology, clinical presentation, instrumental diagnosis, and surgical technique of pediatric SH.

Keywords
► abdominal pain
► children
► hernia sac
► spigelian hernia

Abstract
Spigelian hernia (SH) is a surgical rarity in children, which occurs through slit-like defects in the anterior abdominal wall adjacent to the semilunar line, the convexity lateral line which joins the nine ribs to the pubic tubercle and signs the limit between the muscular and aponeurotic portion of transversus abdominis muscle. As there are no specific symptoms and signs, the diagnosis is difficult, especially in children. We report a case of SH that comes to our observation: a 14-year-old girl presented recurrent abdominal pain associated to intermittent palpable mass in the paraumbilical region. Starting from our case report, we review the literature of pediatric SH from 2000 to 2013 and we describe the anatomy, etiology, clinical presentation, instrumental diagnosis, and surgical technique of pediatric SH.

Case Report
A tall, thin 14-year-old girl without other comorbid conditions or previous abdominal wall trauma, was admitted to our

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outpatient surgical with 1 year history of recurrent abdomi-
nal pain associated to swelling usually appeared on the right 
lower abdominal quadrant after strain and spontaneously 
resolved. Physical examination revealed only tenderness and 
discomfort to palpation of the abdomen, especially in the 
right lower quadrant. US of the right midabdomen, using a 
7.5 MHz linear transducer, noted a fascial plane defect. With 
the suspected diagnosis of SH, the girl underwent open 
surgery under general anesthesia. A median incision pre-
sented a hernia lipoma sticking out from the lateral margin of 
the abdominal rectus. The orifice diameter was approximate-
ly 1.5 cm; it was as a ring like through the fibers of transversus 
and internal oblique muscles. The hernia sac contained a 
small part of the greater omentum, which was reduced. The

| Author | Year | Age | Sex | Side | Comment and associated anomalies | Content of hernia sac |
|--------|------|-----|-----|-----|----------------------------------|-----------------------|
| Al-Salem\(^3\) | 2000 | 3 mo | M | Left | Left undescended testis | Left testis, sigmoid colon |
| | | 1 wk | M | Left | Left undescended testis, micrognathia, cleft palate, malformed ears, right clubfoot, deformed left lower limb | Left testis |
| Losanoff et al\(^11\) | 2002 | 12 y | M | Right | No | Greater omentum |
| White\(^12\) | 2002 | 1 mo | F | Right | Bilateral inguinal hernias | Small intestine |
| Levy et al\(^5\) | 2003 | 1 mo | M | Bilateral | Bilateral undescended testis | Right sac: right testis, small bowel left sac: left testis |
| | | 1 mo | M | Bilateral | Left undescended testis | Left testis, small intestine |
| Raveenthiran\(^13\) | 2005 | Newborn | M | Right | Right undescended testis, imperforate anus, left inguinal hernia, umbilical hernia | Right testis, bowel |
| Vaos et al\(^14\) | 2005 | 20 mo | M | Left | Strangulated low Spigelian hernia | Small bowel, greater omentum |
| Torres de Aguirre et al\(^15\) | 2005 | 26 d | M | Right | Bilateral undescended testis | Small intestine, right testis |
| | | 40 d | M | Bilateral | Right undescended testis | Intestine, testis |
| Aksu et al\(^16\) | 2008 | 4 y | F | Bilateral | Right short lower extremity, right pes valgus anomaly, absent right fibula, scoliosis, multiple skeletal anomalies | Small bowel |
| Christianakis et al\(^17\) | 2009 | 6 y | M | Left | Strangulated low Spigelian hernia | Large omentum |
| Fascetti-Leon et al\(^18\) | 2010 | Newborn | M | Bilateral | Bilateral undescended testis, scalp aplasia cutis | Bilateral testis, small intestine, vas deferens |
| Rushfeldt et al\(^4\) | 2010 | 16 d | M | Right | Right undescended testis | Right testis, small intestine |
| Beasley et al\(^19\) | 2010 | 14 y | M | Left | Traumatic | Fat and vessels |
| Singal et al\(^21\) | 2011 | 3 y | M | Right | Right undescended testis | Right testis, vas deferens, spermatic vessel |
| | | 3 mo | M | Right | Left undescended testis, glanular hypospadias | Left testis, cord structures |
| Present report | 2013 | 14 y | F | Right | No | Greater omentum |
| Bilici et al\(^22\) | 2012 | 6 mo | M | 2 Left 2 Right | Ipsilateral undescended testis No gubernaculum or inguinal canal on the side of SH | Ipsilateral testis |
| | | 1 y | M | 2 Left 2 Right | No gubernaculum or inguinal canal on the side of SH | Ipsilateral testis |
| | | 2 y | M | | | |
| | | 5 y | M | | | |
| Inan et al\(^23\) | 2012 | 20 d | M | Right | Right undescended testis | Right testis |
| Sudhir et al\(^24\) | 2013 | 9 y | M | Right | Traumatic low SH | Small bowel |

Abbreviation: SH, Spigelian hernia.
fascia defect was closed with absorbable suture in layers. After the operation, the patient remains free of symptoms and recurrence.

**Review of Literature**

A Medline database search (2000–2013) revealed 17 articles for a total of 24 cases of pediatric SH (25 including our case) (→ Table 1). There were 22 (88%) males and 3 (12%) females, ratio 7:1. Their ages ranged from newborn to 14 years (average, 3 years). The hernia was situated on the right side in 11 (44%); the left side in 10 (40%), and was bilateral in 4 (16%) cases. In two cases, the hernia was caused by trauma19,24; in another case, there was imperforate anus.13 Two children presented with a strangulated SH.14,17 Twelve patients had anomalies associated to them: 16 (72.72%) undescended testis (13 ipsilateral and 3 bilateral), 2 (9.09%) inguinal hernia, 1 (4.54%) umbilical hernia, 1 (4.54%) glandular hypospadias, and 2 patients presented other anomalies. The contents of the hernia sac was in most cases the testis, 16 (42.10%); followed by small intestine, 11 (28.94%); omentum, 5 (13.15%); vas deferens, 2 (5.26%); cord structures, 1 (2.63%); fat and vessel, 1 (2.63%); spermatic vessel, 1 (2.63%); and sigmoid colon, 1 (2.63%).

**Discussion**

SH protrudes through a congenital or usually acquired defect of the Spigelian fascia, which is the aponeurotic layer between the rectus abdominis muscle medially and the semilunar line laterally.5 The term “Spigelian hernia” is usually referred to hernias located cranially to the inferior epigastric vessels. Those that cross the strip of Spigelian at the triangle of Hasselbach, caudally and medially to the vessels, are called “low” and are a rare entity in pediatric surgery often misdiagnosed as an inguinal hernia.10,24 In 90% of cases, these hernias lies in the so-called SH belt, which is a transverse belt lying 6 cm cranial to the interspinal plane.25 One of the weakest points is the insertion between the semilunar and semicircular line of Douglas. This line marks the caudal end of the posterior lamina of the aponeurotic rectus sheath in the infraumbilical area. In classic SH, the external oblique fascia remains generally intact and the hernial sac is located between the internal oblique muscle and aponeurosis of the transversus muscle (→ Fig. 1). The etiology in children is still unclear; a congenital abnormality in the development of the abdominal wall secondary to a structural change of the internal oblique and transversus abdominis muscles, neurovascular openings in the fascia, infiltration of muscles layers with fat and muscle palsy has been hypothesized.11,18 Most SHs reported in the pediatric age group are spontaneous and idiopathic, although posttraumatic and postoperative SH have been reported.5,11,19,24 On the basis of the musculoaponeurotic defect etiology, diverse factors that increase intra-abdominal pressure or deteriorate the abdominal wall are considered predisposing factors such as collagen disorders, changes in body weight, aging, chronic pulmonary disease, trauma, previous abdominal surgery, previous or concomitant hernias, and imperforate anus.6,13,16 An association of cryptorchidism, umbilical hernia, inguinal hernia, gastroschisis, omphalocoele, meningomyelocele, congenital diaphragmatic hernia, and bladder or cloacal extrophy have been reported for SH.3–5,12,15,16,18,21–23

Among male infants with SHs, 75% presented are associated with cryptorchidism and in most of these the undescended testis was found in the hernia sac.4,7,21–23 There have been many hypotheses on the mechanism of this congenital association. Some authors5,12,21 report that SH is the primary defect and the undescended testis takes the path of least resistance in the abdominal wall. Ravenenthiran26 instead hypothesized that the ectopic location of the testis is the primary abnormality and leads to the formation of a SH by dragging a peritoneal sac along with it. For all these authors, therefore, SH and undescended testis are in a sequence. Because of the high rate of coexistence of this two anomalies, Bilici et al22 suggest for a congenital Spigelian–cryptorchidism syndrome, defined by defects in the Spigelian fascia, hernia sac containing the testis and absence of both the gubernaculum and the inguinal canal; on the other side, Mirilas27 states that this association can be simply accidental: the discussion in literature is still open.

The submission of pediatric SHs is quite uncommon, therefore this often means a delayed diagnosis. They may be asymptomatic or present with no specific clinical symptoms and signs, ranging from pain, swelling, intermittent abdominal pain to an acute abdomen; in addition 20% of SHs in children present with strangulation.4,5,21 Pain is usually limited to the area where the hernia has occurred; it varies in type, severity and location, and depends upon contents of hernia,28 the contraction of the abdominal muscles or other maneuvers that increase intra-abdominal pressure, causing or exacerbating the pain, can help toward the correct
diagnosis. The presence of an intermittent palpable mass along the Spigelian aponeurosis that appears after physical exertion and spontaneously resolves, as reported in our case, makes the diagnosis apparent. In doubtful cases US, CT, and MRI should be considered. A carefully performed US examination with a high-resolution linear transducer may demonstrate the fascial defect, the hernia sac, and its contents; the test can also be conducted in association with Valsalva maneuver to help identify the hernia orifice and evaluate parietal muscle contractility. Differential diagnosis of SH in children includes the following: appendicitis and appendiceal abscess, ventral or inguinal hernia, tumor of the abdominal wall, and spontaneous hematoma of the rectus sheath. SHs are usually small and the risk of strangulation is high, so it should be repaired.

In adults, the validity of laparoscopic treatment is widely confirmed. Recent studies support the possible role of laparoscopy in the diagnosis and treatment of SH also in children, suggesting that it may represent an acceptable therapeutic alternative. The open surgery is still considered the technique of choice in children. In case of palpable hernia, transverse incision is recommended over the protrusion. External oblique aponeurosis is incised in the direction of its fibers to expose the peritoneal sac. Median or paramedian incision is indicated if there is not any palpable hernia or hernia orifice. In pediatric age, recurrent rates following such repairs have been reported to be very low. The hernial sac contains mostly preperitoneal fat, small intestine, colon, omentum, although herniation of a Meckel diverticulum, gallbladder, stomach, urinary bladder, and ovary have been rarely reported in children. After the hernia content reduction, the sac is excised and the fascia defect is closed with suture in layers. When the defect is larger and with coexisting recurrent risk factors, prosthetic mesh, in the preperitoneal space or above the fascia, may be required to reinforce the suture and supports the laxity of Spigelian band.

### Table 2: Main features of Spigelian hernia

- Congenital or acquired defect of Spigelian fascia, located between the rectus abdominis muscle medially and the semilunar line laterally.
- The external oblique fascia is generally intact.
- The hernia sac is located between the internal oblique muscle and aponeurosis of the transversus muscle and contains mostly preperitoneal fat, small intestine, colon, and omentum.
- SH can be associated with cryptorchidism: in most of these cases, the undescended testis is located in the hernia sac.
- Often asymptomatic; symptoms and signs ranging from pain, swelling, intermittent abdominal pain to acute abdomen.
- Differential diagnosis with appendiceal abscess, ventral or inguinal hernia, tumor of the abdominal wall, spontaneous hematoma of the rectus sheath.
- SH in children is small and has to be repaired because of a high risk of incarceration: open surgery is the technique of choice.

**Abbreviation:** SH, Spigelian hernia.

### References

1. Klinkosch JT. Programma Quo Divisionem Herniarum, Novumque Herniae Ventralis Specium Proponit. Berman. Rotterdam; 1764
2. Scopinaro AJ. Hernia on spigels semilunar line in a newborn. Sem Med 1935;1:284–285
3. Al-Salem AH. Congenital spigelian hernia and cryptorchidism: cause or coincidence? Pediatr Surg Int 2000;16(5–6);433–436
4. Rashfeldt C, Oltmanns G, Vonen B. Spigelian-cryptorchidism syndrome: a case report and discussion of the basic elements in a possibly new congenital syndrome. Pediatr Surg Int 2010;26(9):939–942
5. Levy G, Nagar H, Blachar A, Ben-Sira L, Kessler A. Pre-operative sonographic diagnosis of incarcerated neonatal Spigelian hernia containing the testis. Pediatr Radiol 2003;33(6):407–409
6. Moles Morenilla L, Gómez Rubio D, Sánchez Blanco JM, Galindo Galindo A, Recio Moyano O, Brox Jiménez A. [The new congenital Spigelian hernia and cryptorchidism syndrome. Analysis of 16 cases]. Cir Esp 2008;84(3):154–157
7. Durham MM, Ricketts RR. Congenital spigelian hernias and cryptorchidism. J Pediatr Surg 2006;41(11);1814–1817
8. Larson DW, Farley DR. Spigelian hernias: repair and outcome for 81 patients. World J Surg 2002;26(10):1277–1281
9. Stoppa R. Spigelian hernias. In: Chevrel JP, ed. Hernia and Surgery. Springer-Verlag; 1997:267–269
10. Spangen L. Spigelian hernia. Surg Clin North Am 1984;64(2):351–366
11. Losanoff JE, Richman BW, Jones JW. Spigelian hernia in a child: case report and review of the literature. Hernia 2002;6(4):191–193
12. White JJ. Concomitant Spigelian and inguinal hernias in a neonate. J Pediatr Surg 2002;37(4):659–660
13. Raveenthiran V. Congenital Spigelian hernia with cryptorchidism: probably a new syndrome. Hernia 2005;9(4):378–380
14. Vaos G, Gardikis S, Zavras N. Strangulated low Spigelian hernia in children: report of two cases. Pediatr Surg Int 2005;21(9);736–738
15. Torres de Aguirre A, Cabello Laureano R, García Valles C, Garrido P, Al-Salem AH. Congenital spigelian hernia: report of two cases associated to cryptorchidism. Cir Pediatr 2005;18(2);99–100
16. Aksu B, Temizöz O, Inan M, Gençhellaç H, Başaran UN. Bilateral spigelian hernia concomitant with multiple skeletal anomalies and fibular aplasia in a child. Eur J Pediatr Surg 2008;18(3);205–208
17. Christianakis E, Paschalidis N, Filipou P, Rizos S, Smailis D, Filipou D. Low Spigelian hernia in a 6-year-old boy presenting as an incarcerated inguinal hernia: a case report. J Pediatr Surg Reports 2009;3:34
18. Fascetti-Leon F, Gobbi D, Gamba P, Cecchetto G. Neonatal bilateral spigelian hernia associated with undescended testes and scalp aplasia cutis. Eur J Pediatr Surg 2010;20(2):123–125
19. Lopez R, King S, Mãoate K, Beasley S. Trauma may cause Spigelian hernia in children. ANZ J Surg 2010;80(9);668
20. Vega Y, Zequeira J, Delgado A, Lugo-Vicente H. Spigelian hernia in children: case report and literature review. Bol Asoc Med PR 2010;102(4);62–64

### Conflict of Interest

None.
Singal AK, Ravikumar VR, Kadam V, Jain V. Undescended testis in Spigelian hernia—a report of 2 cases and review of the literature. Eur J Pediatr Surg 2011;21(3):194–196

Bilici S, Güneş M, Göksu M, Melek M, Pirinçci N. Undescended testis accompanying congenital Spigelian hernia: is it a reason, a result, or a new syndrome? Eur J Pediatr Surg 2012;22(2):157–161

Inan M, Basaran UN, Aksu B, Dortdogan Z, Dereli M. Congenital Spigelian hernia associated with undescended testis. World J Pediatr 2012;8(2):185–187

Sudhir KT, Salabh G, Saurabh G. Traumatic Spigelian Hernia Due to Handlebar Injury in a Child: A Case Report and Review of Literature. Indian J Surg 2013;75(Suppl):(1):404–406

Skandalakis PN, Zoras O, Skandalakis JE, Mirilas P. Spigelian hernia: surgical anatomy, embryology, and technique of repair. Am Surg 2006;72(1):42–48

Raveenthiran V. Congenital spigelian hernia and cryptorchidism: a distinct clinical syndrome. J Pediatr Surg 2007;42(10):1794–1795

Mirilas P. Congenital spigelian hernia and undescended testis: pitfalls in the transformation of a “coexistence” to “sequence” and “new syndrome”. Eur J Pediatr Surg 2013;23(2):167–168

Mittal T, Kumar V, Khullar R, et al. Diagnosis and management of spigelian hernia: A review of literature and our experience. J Minim Access Surg 2008;4(4):95–98

Ruiz de la Hermosa A, Amunategui Prats I, Machado Liendo P, Nevarez Noboa F, Muñoz Calero A. Spigelian hernia. Personal experience and review of the literature. Rev Esp Enferm Dig 2010;102(10):583–586

Graivier L, Bronsther B, Feins NR, Mestel AL. Pediatric lateral ventral (spigelian) hernias. South Med J 1988;81(3):325–326

Vos DI, Scheltinga MR. Incidence and outcome of surgical repair of spigelian hernia. Br J Surg 2004;91(5):640–644

Lopez R, King S, Maoate K, Beasley S. Laparoscopic repair of paediatric traumatic Spigelian hernia avoids the need for mesh. ANZ J Surg 2011;81(5):396–397