Strangulated epigastric hernia: an uncommon cause of small bowel obstruction

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SUMMARY

Epigastric hernia involves tissue protrusion through a defect in the linea alba between the xiphoid process and the umbilicus, accounting for 1.6-3.6% of abdominal hernias. It typically occurs within 3 inches above the umbilicus and is 2-3 times more common in men, particularly those aged 20–50 years. **Case Presentation:** An 83-year-old man presented with an acute onset of an irreducible, painful epigastric mass and obstipation. Examination revealed a non-pulsatile, tender 10 cm x 10 cm mass with absent bowel sounds. Laboratory investigations were unremarkable. Abdominal X-ray demonstrated valvulae conniventes at the epigastric region, while contrast-enhanced computed tomography (CECT) of the abdomen confirmed an epigastric hernia containing small bowel and mesenteric content, causing small bowel obstruction. Emergency laparotomy revealed 30 cm of gangrenous small bowel. Resection with side-to-side anastomosis was performed. Postoperative recovery was uneventful. Proposed aetiologies include the vascular lacunae hypothesis, where neurovascular bundles perforate the linea alba, and the tendinous fibre decussation hypothesis, suggesting structural weakness due to inadequate fibre decussation. While 75% are asymptomatic, symptoms may include upper abdominal pain or swelling, vomiting, and absence of flatus or bowel opening. Proximal obstructions may mimic gastric outlet obstruction with postprandial nausea or vomiting. CECT is the gold standard for diagnosis, while X-rays have limited utility, especially in proximal obstructions or when assessing for strangulation. Early recognition of strangulated epigastric hernia is crucial due to its rapid progression. Prompt surgical intervention minimises the need for bowel resection and its associated complications.