A Case of Superior Lumbar Hernia

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ABSTRACT: A case of a superior lumbar hernia in a 50 year old woman is described herein. She presented with a 7 X 8 cm soft, nontender, smooth-surfaced mass in the left flank, and barium meal with follow through showed herniation of the descending colon. At operation, a 6 X 5 cm defect was found in the transversalis fascia, which was repaired with mattress sutures to the transversalis fascia together with suturing of the external oblique to the latissimus dorsi. This article presents the above case and reviews the published literature relating to this subject.

KEY WORDS: hernia, superior lumbar hernia, Grynfeltt’s hernia

INTRODUCTION

Lumbar hernias are rarely encountered, being classified as hernias of the lumbar space and subdivided into hernias of the superior lumbar space, known as Grynfelt-Lesshaft’s hernias, and hernias of the inferior or Petit’s lumbar space, known as Petit’s hernias. Approximately 250–300 cases of lumbar hernia have been reported1 and to our knowledge, only 10 have been reported in the Japanese literature.2-4 Of these 10 cases, a superior lumbar hernia was seen in only 2. This brief report presents a case of a superior lumbar hernia that was not associated with either trauma or surgery.

CASE REPORT

A 50 year old woman was admitted to Fukuyama National Hospital with a left flank mass. Physical examination revealed a 7 X 8 cm soft, non-tender, smooth-surfaced, left-flank mass that receded under pressure (Fig. 1). Barium meal with follow through showed herniation of the descending colon (Fig. 2). All other physical and laboratory

Fig. 1. Protrusion in the lateral left upper quadrant of the lumbar area.
findings were negative. Roentgenograms of the chest, ribs and abdomen showed no abnormalities. The patient was diagnosed as having a lumbar hernia and advised to undergo surgery.

Through an oblique skin incision over the mass, a $6 \times 5$ cm defect was found in the transversalis fascia (Fig. 3), which forms the floor of the superior triangle. There was no hernial sac and the left kidney and descending colon were palpable through the fascial defect. This defect was repaired with mattress sutures to the transversalis fascia together with suturing of the external oblique to the latissimus dorsi. The postoperative course was uneventful and the patient was discharged for routine follow up.

**DISCUSSION**

The lumbar region is an area defined superiorly by the 12th rib, inferiorly by the iliac crest, medially by the erector spinae.