Bowel Obstruction due to Sciatic Hernia

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A 72-year-old woman showed massive ascites and sciatic hernia, which was composed solely of ascites, on computed tomography (CT) done in February 2005 as part of a regular follow-up for liver cirrhosis at Aso Iizuka Hospital. Surgical intervention was not chosen as there was no sign of visceral herniation (fig. 1). This patient subsequently presented with abdominal distension in May 2005. CT revealed small bowel obstruction due to

incarcerated sciatic hernia, and she underwent emergency operation (fig. 2). The operation was performed using the transgluteal approach (fig. 3). The sciatic hernia was repaired by suturing the piriformis muscle and the gluteus maximus muscle, without bowel resection because there was no evidence of ischemic change. She was discharged on the 14th postoperative day without any trouble.

Fig. 1. An abdominal CT done 3 months before revealed right-side sciatic hernia. The hernia sac contained only ascites and the patient was asymptomatic at that time (white arrow).

Fig. 2. An enhanced abdominal CT indicated small bowel obstruction due to incarcerated sciatic hernia (white arrow). The small intestinal wall was fully enhanced, indicating that there was no ischemia.

Fig. 3. The operation was performed using a transgluteal approach. The hernia sac protruded through the suprapiriformis area.

Sciatic hernia is extremely rare and it remains unclear whether it is congenital or acquired [1, 2]. In the present case, increased intra-abdominal pressure due to massive ascites may have been the cause of sciatic hernia, and thus the case was considered as acquired sciatic hernia. We have shown that the transgluteal approach is feasible for sciatic hernia because it enables complete repair of the hernia without major surgical stress if visceral organs show no ischemic changes [2, 3].

References

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