protéinurique (Captopril 25 mg puis 50 mg puis 100mg/jour), avec altération progressive de la fonction rénale qui est restée stable aux alentours de 150 mol/l de créatinine sérique.
En janvier 2009, le patient a présenté une aggravation brutale de sa fonction rénale avec une créatinine sérique passant de 169 à 544 puis 734 mol/l en quelques mois; avec stigmate de chronicité et absence de signe de thrombose veineuse rénale au doppler.
La survenue d'épisode d'épistaxis et d'épigastralgies avec présence de congestion pylorique à la FOGD ont motivé des arrêts itératifs de l'anti coagulation.
En mars 2009, il a été admis aux urgences pour infection broncho-pulmonaire, hyperkaliémie à 6,5mmol/l, acidose métabolique sévère (pH = 7,1, HCO3 = 7,9 mmol/l et PCO2= 25 mmHg) et syndrome urémique (créatinine 1629 □mol/l) imposant l'initiation d'une EER en urgence.
Deux mois plus tard, il a été réadmis pour un état de mal convulsif et une altération de la conscience avec mise en évidence de plages hypo denses cortico-sous corticale occipito-pariétales et frontales bilatérales et temporales droites à la TDM, évocatrices d'une thrombophlébite cérébrale. Le patient a été transféré en réanimation où il décède quelques jours plus tard.

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Computed tomography demonstration of an incarcerated lumbur hernia

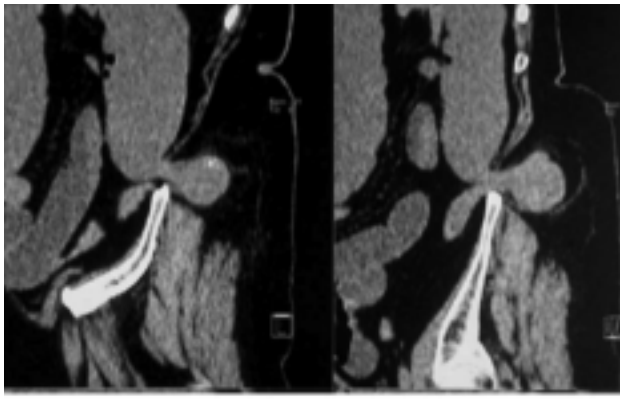
Lumbar hernia is relatively rare, it is due to a defect of the posterior abdominal wall. Approximately 300 cases are reported in the literature [1]. The defect is bounded by the free edge of Latissimus dorsi at the postero medial side, the external oblique at the anterolateral side, and the iliac crest inferior. This Hernia is unusual and it's known as Petit's hernia or inferiorly lumbar hernia. The cause may be congenital, spontaneous, traumatic, or surgical.

We report a new case of incarcerated lumbar hernia diagnosed by CT scan

Case report

An 85-year-old woman with a history of arterial hypertension was admitted to our surgical department with a 4- day history of left lumbar pain with vomiting and constipation. Her vital parameters were normal. Physical examination revealed mild abdominal distension with a tender left lumbar mass. Rectal examination was normal. Blood analyses were normal, except hyper leucocytes (12 000 □/L). Abdominal films showed a distended bowel with colonic air fluid levels. Computed tomography (CT scan) revealed incarceration of a short segment of descending colon through the inferior lumbar triangle of Petit (Figure). The defect was about 3 cm. The colic segment near to the hernia was dilated. The patient underwent laparotomy after initial resuscitation. Surgical exploration showed distension of the caecum and transverse colon, with incarcerated descending colon through a left inferior lumbar triangle of Grynfeltt. The distal sigmoid colon was collapsed. The colon was reduced and no signs of acute tranmural ischemia were found. Lumbar hernia was treated with primary repair. The postoperative course was uneventful and the patient was discharged five days after surgery.

Figures 1 : RComputed tomography revealing incarceration of a short segment of descending colon through the inferior lumbar triangle of Petit



Conclusion

Large bowel obstruction is a very rare complication of lumbar hernia. Constriction is uncommon but can occur with stangulation of the neck of the sac causing necrosis of the bowel wall. Earlier diagnosis of non complicated hernia should be of primary importance.

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