PREOPERATIVE DIAGNOSIS:,1. Acute bowel obstruction.,2. Umbilical hernia.,POSTOPERATIVE DIAGNOSIS:,1. Acute small bowel obstruction.,2. Incarcerated umbilical Hernia.,PROCEDURE PERFORMED:,1. Exploratory laparotomy.,2. Release of small bowel obstruction.,3. Repair of periumbilical hernia.,ANESTHESIA: , General with endotracheal intubation.,COMPLICATIONS:, None.,DISPOSITION: , The patient tolerated the procedure well and was transferred to recovery in stable condition.,SPECIMEN: , Hernia sac.,HISTORY: ,The patient is a 98-year-old female who presents from nursing home extended care facility with an incarcerated umbilical hernia, intractable nausea and vomiting and a bowel obstruction. Upon seeing the patient and discussing in extent with the family, it was decided the patient needed to go to the operating room for this nonreducible umbilical hernia and bowel obstruction and the family agreed with surgery.,INTRAOPERATIVE FINDINGS: , The patient was found to have an incarcerated umbilical hernia. There was a loop of small bowel incarcerated within the hernia sac. It showed signs of ecchymosis, however no signs of any ischemia or necrosis. It was easily reduced once opening the abdomen and the rest of the small bowel was ran without any other defects or abnormalities.,PROCEDURE: , After informed written consent, risks and benefits of the procedure were explained to the patient and the patient's family. The patient was brought to the operating suite. After general endotracheal intubation, prepped and draped in normal sterile fashion. A

midline incision was made around the umbilical hernia defect with a #10 blade scalpel. Dissection was then carried down to the fascia. Using a sharp dissection, an incision was made above the defect superior to the defect entering the fascia. The abdomen was entered under direct visualization. The small bowel that was entrapped within the hernia sac was easily reduced and observed and appeared to be ecchymotic, however, no signs of ischemia were noted or necrosis. The remaining of the fascia was then extended using Metzenbaum scissors. The hernia sac was removed using Mayo scissors and sent off as specimen. Next, the bowel was run from the ligament of Treitz to the ileocecal valve with no evidence of any other abnormalities. The small bowel was then milked down removing all the fluid. The bowel was decompressed distal to the obstruction. Once returning the abdominal contents to the abdomen, attention was next made in closing the abdomen and using #1 Vicryl suture in the figure-of-eight fashion the fascia was closed. The umbilicus was then reapproximated to its anatomical position with a #1 Vicryl suture. A #3-0 Vicryl suture was then used to reapproximate the deep dermal layers and skin staples were used on the skin. Sterile dressings were applied. The patient tolerated the procedure well and was transferred to recovery in stable condition.