Epigastric Hernia

- Occurs usually through the defect in the fibres of linea alba anywhere between Xiphoid to umbilicus.
- When close to the umbilicus they are called supraumbilical hernias.
- 10% common.
- 20% have multiple defects. The most common cause of ‘recurrence’ is failure to identify a second defect at the time of original repair.
- Patients are often manual workers between 30-45 years.

Pathology

- Begin with a transverse split in the midline raphe so, in contrast to umbilical hernias, the defect is elliptical.
- defects are usually less than 1 cm in maximum diameter and commonly contain only extra peritoneal fat, which gradually enlarges, spreading in the subcutaneous plane to resemble the shape of a mushroom.
- When very large they may contain a peritoneal sac but rarely any bowel.

Clinical features

- can be very painful even when the swelling is the size of a pea, due to the fatty contents becoming nipped sufficiently to produce partial strangulation.
- The pain may mimic that of a peptic ulcer but symptoms should not be ascribed to the hernia until gastrointestinal pathology has been excluded.
- A soft midline swelling can often be felt more easily than seen.
- may be locally tender.
- Unlikely to be reducible because of the narrow neck.
- may resemble a lipoma.
- A cough impulse may or may not be felt.

Management

- Very small epigastric hernias have been known to disappear spontaneously, probably due to infarction of the fat.
- Small to-moderate-sized hernias without a peritoneal sac are not inherently dangerous and surgery should be offered only if the hernia is sufficiently symptomatic.

Surgery

- This may be done by open or laparoscopic surgery.
- The defect in the linea alba is closed with non-absorbable sutures in adults and absorbable sutures in children.
- In larger hernias and when a peritoneal sac is present, the surgical approach is similar to an umbilical mesh repair.