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Bac	We present the case of a 57-year-old female with a giant Spigelian hernia presenting as a small bowel obstruction.
S a	Spigelian hernias represent less than 2% of abdominal wall defects. It affects mainly females, and it usually manifests with vague symptoms. It should also be considered a possible etiology of small bowel obstructions, but this scenario is even rarer. Unlike other hernias, due to their localization and small size, diagnosing them during physical examination tends to be complicated. Therefore, imaging studies are often required to characterize the defect. Spigelian hernias should be repaired with either open or laparoscopic surgery Once detected.
C c	Until now, a standardized treatment for this pathology has not been described. There are few case reports about this pathology, and surgeons' experience is still limited. Preoperative techniques such as pneumoperitoneum or botulinic toxin would be useful in cases where the Tanaka index is over 25%. However, in select cases, these procedures can be avoided.
K W	Spigelian hernia; giant hernia; small bowel obstruction

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ing the hernia sac, the content (mainly small bowel) could be gradually reduced into the abdominal cavity, showing a 7 cm wall defect on the fascia. After checking that the omentum would separate abdominal content from the polypropylene mesh, we decided on an intraperitoneal repair technique. The mesh was fixed with a transmuscular PDS 1 suture. We closed the peritoneum and muscular plane above the mesh, and the surgical procedure ended with positioning two subcutaneous drains and wound closure. The patient was discharged on postoperative day 3 (Figure 1C). No major complications or recurrence were reported after two years of follow-up.

Discussion

Spigelian hernia is a rare, intriguing abdominal wall hernia.[7] Predisposing factors include obesity, multiple pregnancies, rapid weight loss, chronic obstructive pulmonary disease, chronic constipation, prostatic enlargement, ascites, trauma, and previous surgery weakening the semilunar line.[1]

The symptoms that encourage the patient to consult are usually pain (unspecific), palpable resistance in the anterior abdominal wall, or signs of intestinal obstruction.[6] A giant abdominal bulgy mass is a rare presentation condition. The diagnosis and, eventually, the surgical technique are not standardized; this is why every clinical situation is unique, and the surgeon needs to plan the surgical approach and select the best technique for each case.[10]

Multiple preoperative procedures have been described. Worldwide, it is accepted that patients with Tanaka indices over 25% would benefit from preoperative techniques.[11] For this type of defect, one of the leading technical difficulties has been parietal closure without tension. In the 1970s, Moreno-Egea proposed a preoperative pneumoperitoneum to enable the stretching of the abdominal muscles.[12] More recently, other techniques have been proposed to facilitate parietal closure; for example, the use of botulinum toxin in the abdominal anterolateral wall muscles.

In our experience, preoperative techniques should be reserved for those patients whose hernial content cannot be entirely reduced and not according to the Tanaka index value. There are few case reports about this pathology in the literature, and surgeons' experience is still limited. Elective surgery should be chosen when possible, and the repair technique should be the most suitable/ beneficial for each patient.

Conclusion

Until now, a standardized treatment for this pathology has not been described. Preoperative techniques such as pneumoperitoneum or botulinic toxin would be useful in cases where the Tanaka index is over 25%. However, in many cases, these procedures can be avoided. We consider our case interesting not only because of the defect measures and atypical presentation but mainly because of the way it could be repaired.

Lessons Learned

Our patient presented with a small bowel obstruction and underwent elective open surgery. Despite its size, we could repair it without needing preoperative pneumoperitoneum or botulinum toxin. Undoubtedly, it is a rare type of hernia, and most cases reveal minor wall defects than can be restored with primary repair.

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