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: Internal Herniation Through the Foramen of Winslow: A Rare Cause of Mechanical Small Bowel Obstruction

Background:

The **F**oramen **o**f **W**inslow (FOW) is a small natural anatomical communication between the lesser and greater sacs. It is usually kept closed by the normal intra-abdominal pressure. Small bowel obstruction (SBO) due to internal herniation through the FOW is rare. Literature suggests that this condition is more common in manual workers (men), patients with history of cho-lecystectomy, long small bowel mesentery, floating right colon, and gastrohe-patic ligament defect.

Aim:

To present a rare cause of SBO due to herniation through the FOW, the operative findings, and its management.

Methods:

Case presentation

Results:

Not Applicable

Discussion:

A 66 years old female presented acutely with a 12 hours history of a clinical picture of SBO. She was known to have thromobocythaemia, hypertension, and history of laparoscopic cholecystectomy. Her blood tests were unremarkable apart from slightly raised lactate levels. CT scan of abdomen & pelvis showed SBO with ischaemic changes, and free intra-peritoneal fluid.

She underwent an emergency diagnostic laparoscopy which showed blood stained free intra-peritoneal fluid, mobile high riding caecum, with dilated proximal and collapsed distal small bowel loops. The site of obstruction was identified during the course of laparoscopy (herniation of the distal small bowel into the lesser sac through the FOW, with bulging of the small bowel through the lesser omentum). Reduction of the distended small bowel loops was not possible laparoscopically hence the decision was made to convert to laparotomy.

The herniation was reduced after entering the lesser sac through the lesser omentum. The herniated bowel was reduced by bimanual manipulation (left fingers in the FOW and the right fingers in the lesser sac).

After the complete reduction of the herniated small bowel back into the greater sac, a 70cm segment of ischaemic small bowel was resected with primary anastomosis. *Suture closure of the FOW was considered but not carried out to avoid IVC injury or portal vein thrombosis. There are two schools of thoughts in literature in this concept; in favour of or against FOW closure. The patient had an uneventful recovery and was discharged home five days later. The histopathology report confirmed small bowel ischaemic infarction.*