

PERINEAL HERNIA

A hernia is the protrusion or extension of an organ or tissue through an abnormal opening in the abdominal wall. A perineal hernia results from a weakening of the pelvic muscles that support the rectum, which subsequently stretch and bulge with fat or abdominal tissue.

Perineal hernias are seen in dogs, and rarely cats. The Boston Terrier, Boxer, Collie, Welsh Corgi, Pekingese, Dachshund and Old English Sheepdog are the most commonly affected breeds. The vast majority of perineal hernia cases occur in middle aged to older intact males. In these dogs, testosterone causes a chronic enlargement (hypertrophy) of the prostate gland. As the animal strains to urinate and defecate around the enlarged prostate, the tissues adjacent to the rectum weaken, allowing fat or abdominal organs to push out around the rectum and form a pouch under the skin. This pouch may enlarge when straining pushes tissue out into it and may become smaller as tissue moves back into the abdomen.

Females are rarely affected due to the greater strength, size and area of the rectal attachments of their levator ani muscles (one of the pelvic muscles) and their lack of a prostate gland. Approximately one third of the hernias are bilateral (occurring on both sides).

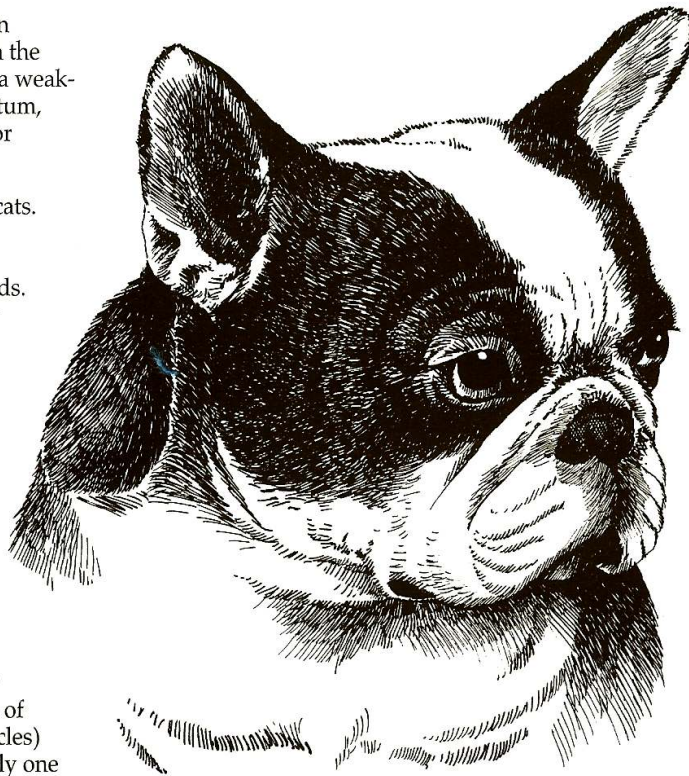
Cats with perineal hernias often have chronic constipation secondary to megacolon. Megacolon should be ruled out as a cause of straining because the surgical treatment for perineal hernias and megacolon are different.

■ SYMPTOMS

The most common owner complaints of dogs with perineal hernias are chronic constipation, straining to defecate, and a swelling on either side of the rectum. Other signs may include straining to urinate, pain on defecation, fecal incontinence, and altered tail carriage.

■ DIAGNOSIS

The hernia is diagnosed based on the patient's history and physical examination. A defect in the pelvic diaphragm musculature or sacculations (out pouching) of the rectum are usually detected



on rectal palpation. Fatty tissue is usually present in the hernia. A non-reducible (unmovable) fluid-filled mass in the hernia suggests displacement of the urinary bladder. In all cases, both sides of the pelvic diaphragm should be palpated. While the patient may appear to be unilaterally affected, both sides are often weakened.

If the prostate is enlarged, the cause of this enlargement must be determined. Benign hyperplasia, abscessation, cyst formation, and tumors must all be considered and treated appropriately. Castration is recommended in all cases due to the effects of testosterone on the prostate gland and perianal musculature.

TREATMENT

Conservative Therapy may be tried to palliate dogs with minimal signs, or in those patients where the anesthetic risk is too great to consider surgery. Medical management is rarely successful in permanently controlling the clinical signs that are associated with perineal herniation.

These measures may also be used as an adjunct to surgical repair:

- 1) *Diet high in fiber and moisture content.*
- 2) *Stool softeners such as Metamucil or Colace.*
- 3) *Digital (manual) removal of impacted feces.*

Surgical Repair is the treatment of choice for most cases of perineal hernia. This is achieved by suturing specific muscles together to reform a pelvic diaphragm. If there is insufficient tissue available to close the defect, an implanted surgical mesh may be used.

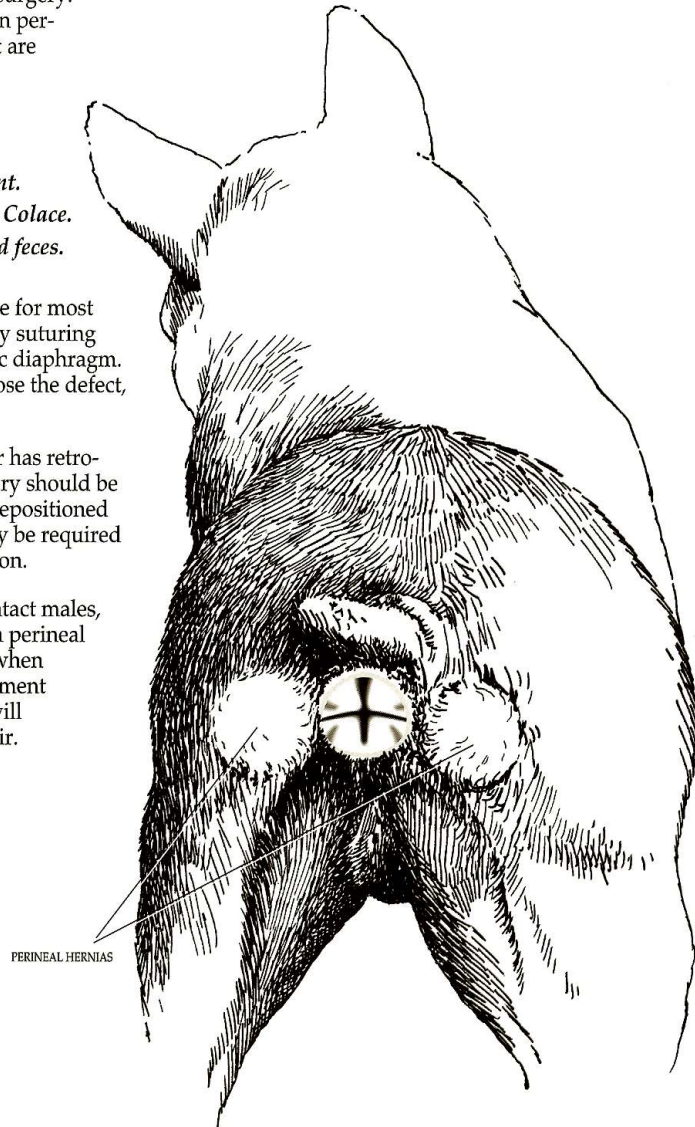
In those cases where the urinary bladder has retroflexed (flipped back) into the hernia, surgery should be performed immediately, and the bladder repositioned into the abdomen. Abdominal surgery may be required to stabilize the bladder in its normal position.

Castration should be considered in all intact males, due to the potential hormonal influence on perineal herniation. This is particularly important when the prostate is increased in size, as enlargement of this gland may cause straining, which will place unneeded stress on the surgical repair.

POSTOPERATIVE CARE

Antibiotic therapy is continued after surgery, as the surgical site is considered contaminated due to its location. Stool softeners and a low residue diet are used for the first few weeks to minimize stress on the repair

as the prostate shrinks in size and the chronic straining subsides. An Elizabethan Collar is worn until the sutures are removed to prevent the patient from licking at the suture line.



Veterinary Surgical Services
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Operative Report

Date: 2006
Case No: 6859
Patient: Chip Sample
Ref Vet: Another DVM
Pre OP Dx : Right Sided Perineal Hernia



Pre Operative Notes Chip has a very large perineal hernia on the right side of rectum. The left side may be involved but only palpates to the right. All other parameters are wnl. IV catheter in place, 1 g cefazolin IV, Ace/ Torb.

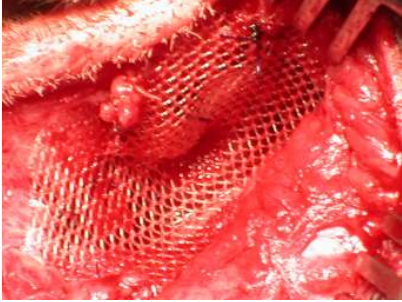
Operation In Detail:

The dog was placed in ventral recumbancy. The perineal area was clipped and prepped for surgery. A 10 cm longitudinal incision was made to the right of the rectum over the hernia. The subcutaneous tissue was incised along the same line. It became immediately apparent that this was a bad hernia. Most of the hernia incorporated large amounts of fatty tissue. No organ involvement. Found was a encapsulated hard mass about 4 x 2 cm. There were extensive adhesions and fibrous indicating the chronic nature of this hernia. The hard mass was carefully dissected out. On cross section it was boney and hard in some areas and had a hollow core. It was held for histopathology. The additional adhesions were bluntly dissected till the abdominal fat could be reduced into the abdomen.



Next, the fascia and periosteum along the caudal border of the ischium and internal obturator m were incised. Using periosteal elevators, the internal obturator m was elevated from the ischium. The muscle was transposed dorsaomedially and sutured with 0-PDS interrupted to the coccygeus, levator ani, and exteternal muscle groups.





A prolene mesh was then sutured to the ventral surface of the internal obturator and surrounding tissues. The subcutaneous tissue was closed with 2-PDS in a simple continuous pattern, followed by a subcuticular, The skin was closed with 2-0 PDS in a simple interrupted pattern.

Post Operative Notes:

Stool softeners, such as DSS are helpful. Feed canned food only that are high in fiber (i.e. W/D) for two weeks.



Post Operative Instructions:

No running, jumping or playing for a minimum of 6 weeks. Suture removal in 10-14 days if desired See discharge instructions for additional care.

Give antibiotics and analgesics as directed. NO DRY DOG FOOD !!! High fiber diet and stool softeners next 6 weeks.

Please call if you have any questions or problems.

Mitch T. Rosenzweig, DVM