# Incarcerated Internal Hernia Posterior to the Iliac Vessels After Uncomplicated Radical Cystectomy

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Radical cystectomy (RC) with pelvic lymph node dissection (PLND) remains the standard of care for patients with muscle-invasive bladder cancer[1]. Despite improvements in surgical technique and perioperative care, complications of any grade occur in up to 58% of patients after RC, with infectious and genitourinary complaints being the most common[2]. We present a clinical picture of a rare complication: an incarcerated internal hernia of the small bowel behind the external iliac artery after an uncomplicated RC, PLND, and ileal conduit in a 77-year-old male.

The patient presented to a community hospital with a 2-day history of recurrent episodes of nausea, vomiting, and non-specific, crampy abdominal pain 6 weeks after RC. His abdomen was tender on examination, but there was no sign of peritonitis. Bloodwork revealed mild leukocytosis and an abdominal computed tomography (CT) demonstrated no specific cause for his symptoms. A repeat CT 4 days later demonstrated abrupt termination of oral contrast in the right hemipelvis, immediately adjacent to the external iliac artery (**Figure 1**, left). Edematous small bowel was trapped posterior and inferior to the iliac artery, consistent with internal herniation. At this point, the patient had signs of peritonitis with rebound tenderness.

The patient underwent emergent laparotomy. The intraoperative findings confirmed small bowel obstruction secondary to entrapment of the bowel behind the right external iliac artery that had been skeletonized by prior PLND (**Figure 1**, right). The bowel was gangrenous and required resection. A re-look laparotomy was performed 2 days later with restoration of intestinal continuity. One week following his final procedure, the patient was transferred to a community hospital near his home in stable condition, and he made a full recovery.

## References

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**Competing Interests**

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**FIGURE 1.**
Incarcerated internal hernia of the small intestine. Both the computed tomography (left panel) and the intraoperative photograph (right panel) show the gangrenous ileum (marked with star) trapped below the right external iliac artery (outlined with white lines). The point where the ileum traverses posterior to the artery is marked with the block arrow and the dilated small bowel proximal to this is marked with a triangle. The resected small bowel is shown in the inset.