

## Grynfeltt's Hernia: Think it in Case of a Lumbar Mass

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### Abstract

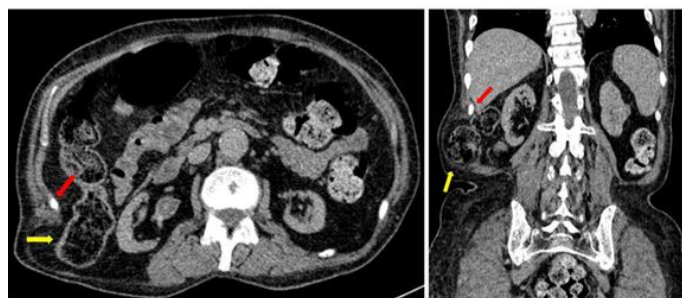
Lumbar hernia is a rare defect of the posterior abdominal wall, first described in 1672 by Barrett. Grynfeltt and Lesshaft described herniation of the upper lumbar triangle in 1886 and 1870, respectively. It occurs due to weakening of the transversalis fascia and transversus abdominis fascia. As a consequence, this weakening allows the abdominal contents to protrude through the upper lumbar triangle.

**Keywords:** Grynfeltt; Lesshaft Hernia; Lumbar mass; Imagery

### Clinical Image

Grynfeltt-Lesshaft hernia is a rare defect of the posterior abdominal wall at the level of the upper lumbar triangle, described by Grynfeltt and Lesshaft in 1886 and 1870, respectively [1]. It Occurs due to weakening of the transversalis fascia and transversus abdominis fascia allowing abdominal contents to protrude through the upper lumbar triangle, a region defined medially by the quadratus lumborum muscle, inferiorly by the internal oblique muscle and superiorly by the 12th rib. The contents may include retroperitoneal organs, intraperitoneal organs and retroperitoneal or epiploic adipose tissue [2].

They represent less than 2% of abdominal wall hernias and only a little over 300 cases reported in the literature [1]. They can be congenital (20%) or acquired in the majority of cases (82%) [1]. Advanced age, obesity, muscle atrophy and chronic obstructive pulmonary disease or any other condition that produces a persistent increase in intra-abdominal pressure are the main risk factors [2].



**Figure 1:** Abdominal CT scan with contrast injection in axial and coronal section showing a right posterior abdominal parietal defect below the 12th rib (red arrow) with protrusion of the right colonic angle and adjacent fat (yellow arrow) at the level of the right upper lumbar triangle (Grynfeltt triangle).

Clinically, the patient may present with an asymptomatic lumbar mass, expansive on coughing, physical exertion or trunk anteflexion; a lumbar mass with back pain; or a lumbar mass with vague abdominal symptoms [2]. The main differential diagnosis is lipoma [1].

Ultrasound shows a subcutaneous mass, well circumscribed with fat content [2]. The CT scan is the examination of choice to study the anatomy of the lumbar region, the extension of the defect, the presence or absence of viscera in the hernia (Figure 1) and possibly the search for any complications [1,2] (Figure 1).

Described repair techniques include anatomic closure, covering the fascia with musculofascial flaps, and placement of mesh prostheses via the retroperitoneal or transabdominal laparoscopic approach [1,2].

### References

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