

Grynfeltt-Lesshaft hernia

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A 76-year-old woman presented with a painful growing mass on her left lower back since 10 months. The pain was intermittent, but had become worse during the last 10 days. No history of previous procedures and trauma was reported. Physical examination showed a left lumbar tender mass which increased especially during Valsalva's maneuver, just above the 12th left rib, with no signs of incarceration or peritonitis. Laboratory tests, such as urinalysis and blood count were both unremarkable. Abdominal Computed Tomography (CT) revealed the presence of small bowel and mesenteric fat protruding through the superior lumbar space (Fig. 1), also known as the Grynfeltt-Lesshaft's triangle, located in the upper posterolateral abdominal wall. Laparoscopic surgery was performed and confirmed the diagnosis of Grynfeltt-Lesshaft hernia. Subsequent follow-ups have been uneventful.

Back lumbar hernias are rare wall defects of the lumbar area [1-3], a region bound by the external oblique muscle laterally, the *erector spinae* muscle medially, the iliac crest inferiorly and the 12th rib superiorly [1,2]. The region is divided into two spaces, the superior one known as Grynfeltt-Lesshaft's triangle, and the inferior space, also called Petit's triangle [1-3]. Grynfeltt-Lesshaft hernias are more common [1], as the superior triangle is larger [2]. Clinically, they may present from asymptomatic to painful masses, usually reducible and exercise-related [3]. Even though the diagnosis is clinical, CT imaging study is broadly recommended [1-3]. Its treatment remains surgical; however, the optimal technique should be selected on an individual basis.



Figure 1 Abdominal Computed Tomography (CT) scan showing small intestine and mesenteric fat (arrow) protruding through the superior lumbar space (Grynfeltt-Lesshaft's triangle). ES: *Erector spinae* muscle. LD: *Latissimus dorsi* muscle. EO: *External oblique* muscle. IO: *Internal oblique* muscle. TA: *Transversus abdominis* muscle.

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