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THEME Inguinal hernia

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Strangulated left adnexa in an irreducible inguinal hernia due to sizable uterine fibroid.

A case report.

Introduction

Inguinal hernia accounts for approximately 75% of all abdominal hernias, with a lifetime risk of developing up to 45% for men and 6% for women, and inguinal hernia repair is one of the most common operations worldwide with more than 20 million procedures annually.

Omentum, small bowel and colon are the most commonly herniated organs. Ovary, fallopian tube or uterine ligaments as a content of an inguinal hernia is a rare condition, with most case reported in paediatric population and a relative scarcity in data regarding in adult females. Prevalence is not well-documented, with the largest single centre, retrospective review by Gurer et al reporting an incidence of 2.9%.

Case presentation

A fifty-year-old gravida3, para1 female patient with a history of previous caesarean section presented in the Emergency Department with reported left lower abdominal pain and palpable swelling in the inguinal area. Patient was 3 years postmenopausal, with history of uterine fibroids, a previous abdominal myomectomy and a recent diagnosis of a new sizeable fibroid. Symptoms onset was 7 days prior to examination with an acute onset deterioration of abdominal and inguinal pain.

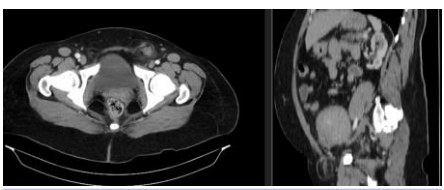

Fig. 1: CT scan revealing a sizeable uterine fibroid and a herniated left adnexa with early signs of strangulation

On clinical examination a palpable irreducible painful mass of the left groin was recognized, with mild tenderness on LIF examination. Laboratory findings were unremarkable apart from mildly elevated CRP. Due to patient's history a gynaecological examination and transvaginal ultrasound were performed, revealing a sizeable uterine fibroid with and suboptimal visualization of the adnexa bilaterally. A CT scan was requested disclosing a left inguinal hernia containing part of the left adnexa with indirect signs of strangulation and significant increase of known fibroid compared to a recent MRI scan.

An explorative laparotomy was performed and a strangulated left adnexa was revealed. The left adnexa was reduced and a total hysterectomy and bilateral oophorectomy was performed. An intraperitoneal herniorrhaphy was preferred over a mesh repair due to moderate blood loss and borderline ischemia of the reduced adnexa. Postoperative course was uneventful and the patient was discharged on the seventh day post-operatively. On two-month follow-up patient is asymptomatic with no clinical signs of hernia recurrence, while on six-month follow-up a mildly symptomatic, CT-confirmed left inguinal hernia was diagnosed, with an elective repair pending.

Fig. 2: Ischemia of the left adnexa – no malignancy reported

Conclusions

Inguinal hernia is one of the most common benign conditions of general surgery, with acute complications posing a significant healthcare burden. Although less common in female patients and despite the fact that reproductive organs are rarely encountered as a hernia content, an increase of intra-abdominal pressure or a relaxation of pelvic structures may lead to this uncommon presentation. The above case presentation sets an example of a diagnostic challenge, as well as an interesting correlation between an intra-abdominal organ condition leading to an abdominal wall emergency.

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