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CLINICAL QUIZ

Right Inguino-scrotal Swelling: An Operative Surprise?

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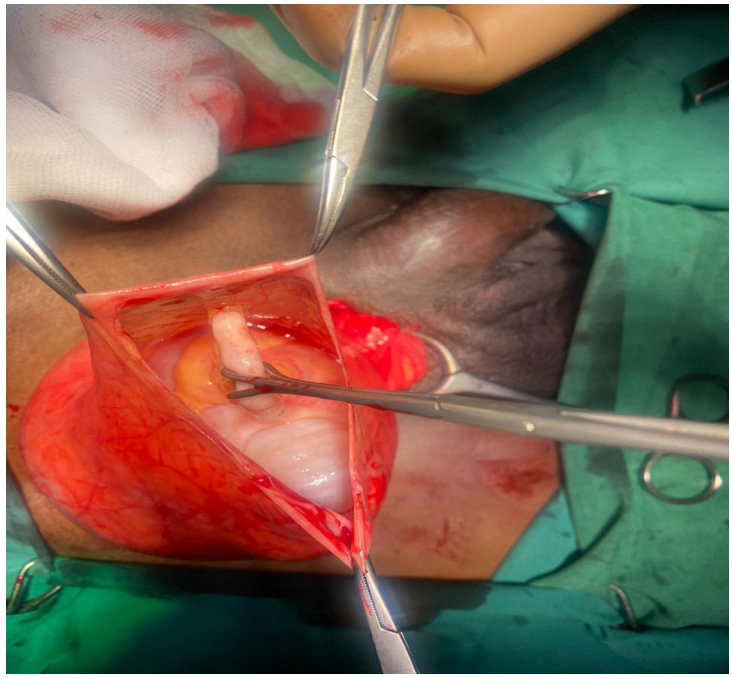

Figure 1: A vermiform-like structure was identified inside the right inguino-scrotal sac

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QUESTION

A 70-year-old gentleman presented with irreducible right inguino-scrotal swelling since 1-day prior to admission. He has underlying chronic lung disease and reducible right inguinal swelling since 3 years ago. He denied constipation, lower urinary tract symptoms or history of heavy weight lifting. On examination, the swelling measured 8x3 cm, oval in shape, was unable to get above the swelling and extending into the right scrotal region. The swelling was tense and irreducible. Surgery was decided on him. Intraoperative findings are seen in Figure 1. Provide the provisional diagnosis and outline the management plan of such pathology.

ANSWER

The provisional diagnosis of this case is Amyand's hernia. Historically, it was introduced in 1735 by Claudius Amyand, a French-born English surgeon who successfully performed and recorded the repair of an inguinal hernia in an 11-year-old patient. It is rare with an incidence of 1% whereby the vermiform appendix is found in an inguinal hernia sac. It can be identified mostly during elective inguinal hernioplasty or imaging incidentaloma, while others may present as acute appendicitis, strangulation, abscess or perforation. Some patients presented as Fournier's gangrene, with clinical features of lower abdominal pain, fever and pus discharge from the right inguinoscrotal region. Management of the patients with Amyand's hernia depends on their presentation. The unstable patients such as those with haemodynamic instability mandate a vigorous resuscitation prior to surgery. The correction of acid-base balance, electrolytes imbalance, urine output and antibiotics are prudent in the initial management.

Operative management of Amyand's hernia has to be as important as managing the appendix itself. The decision to perform appendicectomy or not is as important as to repair the hernia by mesh or without mesh. Lossannof and Basson hence had proposed a classification for Amyand's hernia. Type 1 contains normal appendix and reduction of content with mesh repair is recommended. Type 2 is confined to the infection from appendicitis, hence appendicectomy through the hernial sac with non-mesh hernia repair is advocated. Type 3 is an extensive infection usually from perforated appendicitis that causes peritonitis. These require laparotomy, washout, or more extensive resection in addition to primary hernia repair without a mesh. Type 4 is Amyand's hernia with co-existing intraabdominal pathology that needs to be further investigated.