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A Rare Case Report: Emergency Shouldice Operation of a Patient with Large Incarcerated right-sided Inguinoscrotal Hernia

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Abstract

The case is about a 47-year old man with a giant right-sided incarcerated inguinoscrotal hernia. That had a considerable psychological impact on patient's life, leading to social isolation. Hernia was repaired as an emergency operation, in Shouldice technique. Patient's life changed completely.

Keywords: Giant hernia; Incarcerated hernia; Shouldice operation

Introduction

Giant inguinoscrotal hernias are defined as those extending below the midpoint of the inner thigh in the standing position. Large inguinoscrotal hernias are not clearly defined and are rare nowadays [1-3]. There are result of neglecting the hernia, usually caused by a fear of surgery, ashame, long distance from health facilities, psychiatric problems etc. Surgical repair is often challenging and difficult because of adhesions of the content within the sac, necrosis after incarceration and need for a resection and anastomosis and sometimes even loss of a domain [4,5].

Patient

A 47-year old man visited our emergency surgery ambulance due to a painful, incarcerated right-sided inguinoscrotal hernia **(Figure 1).** He had had the hernia for about 20 years, during that time the hernia was progressively increasing in size, incarcerating from time to time, but was always till that time reducible. The patient had a cosmetic and a lot of (functional) problems, especially while sitting, walking, standing for a longer period or trying to run.

Sport was not possible and because the hernia repressed his genitals, his penis was drawn into the sack (buried) and not visible at all. That had a huge impact on his sex life (which didn't exist). He had some emotional and behavioral problems - had no confidence, had low self-esteem, couldn`t look into people`s eyes while talking etc. The reason for his late presentation has been ashame and financial constraints.

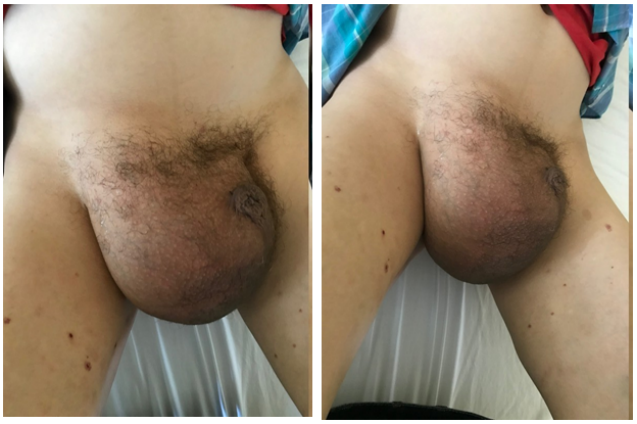

Figure 1: Incarcerated right-sided inguinoscrotal hernia.

Treatment

At the time of examination, hernia extended to the proximal third of the inner thigh, in standing position. The hernia was tensed, painful, non-reducible and the skin was normally colored (no trophic changes), without signs of infection or necrosis. The right testis was not palpable. Diaphanoscopy showed bowel and bowel sounds could be heard in scrotum.

Other than that, the patient was a healthy young man with no history of any chronic diseases.

Preoperative preparations included electrocardiogram, chest X-ray and laboratory data. Computer tomography scan hasn't been made because an urgent operation was planned, we hadn't expected additional valuable information and wanted to spare the patient unnecessary radiation. Patient received a 1000 ml of 0.9 % NaCl solution with 1 g Cefazolin and a emergency operation in general anesthesia followed.

Intraoperatively we have found approximately 1 m of loops of vital, small bowel with congested wall within the hernia sac, incarcerated but not strangulated.

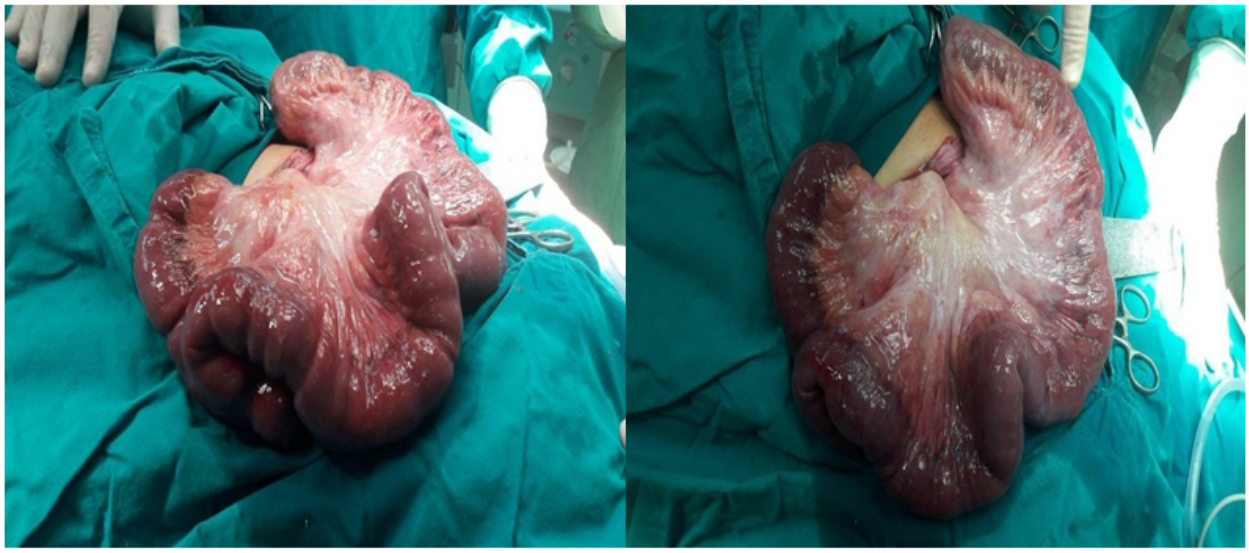

Figure 2: Inguinal ring structure.

Reduction of hernia content, after enlargement of the internal ring **(Figure 2)** (anulus inguinalis profundus) into the abdominal cavity was possible, so there was no need for a resection.

Herniorrhaphy **(Figure 3)** was made with Prolen 3/0 (we would always had chosen that technique), without drainage (which was a mistake on our opinion and we would now always suggest a drainage).

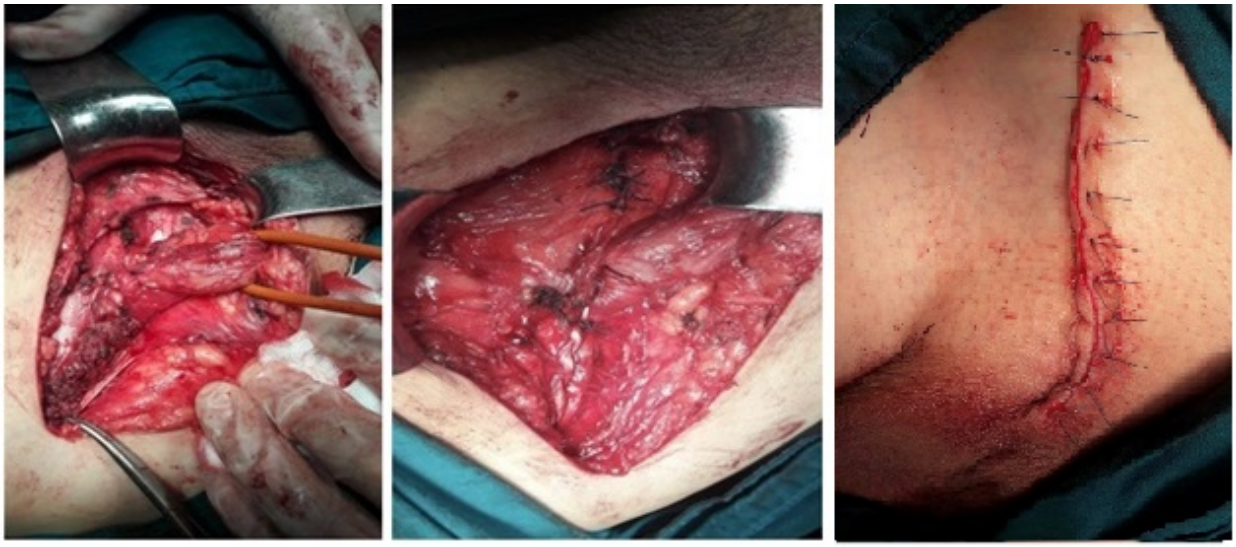

Figure 3: Herniorrhaphy.

Discussion

Inguinal hernia is one of the most common general surgical operation world-wide. Giant and large inguinoscrotal hernias are rare but existing entities. We are having two or three cases pro year in our hospital [4,5]. The delay in presentation to a surgeon is multifactorial, usually caused by a fear of surgery, ashame, long distance from health facilities, psychiatric problems, financial constraints etc. Problems caused by the hernia are multiple. There are cosmetic and a lot of (functional) problems, especially while sitting, walking, standing for a longer period or trying to run. Sport is usually not possible and because the hernia represses the genitals penis is often drawn into the sack (buried) and not visible at all. That has a huge impact on patients sex life and a some emotional and behavioral problems could arise (like no confidence, low self-esteem, couldn`t look into people`s eyes while talking etc.) and that leads to social isolation and disfunctioning.

The recurrence rate is variable and may reach 30%. Postoperatively the patient has been seen on regular follow-up for one year. He developed a inguinoscrotal hematoma, that

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was treated conservatively and disappeared after 6 weeks. Beside that he has had no complications and there has been no recurrence till today. The redundant scrotum was treated conservatively and it retracted completely within 6 weeks [6-10].

Conclusion

Giant and large inguinoscrotal hernias are rare in Europe today. We can find them in some country's with less developed health care systems, in some psychiatric patients or individually cases of, for a lot of reasons neglected, normal hernias. Because having considerable psychological impact on patient's life they often leading to complete social isolation and dis-functioning. With the time the surgical repair becomes more challenging and difficult because of formation of adhesions of the content within the sac, necrosis after incarceration or volvulus and need for a resection and anastomosis. Sometimes even loss of a domain happens so the operation should follow as soon as possible and it will have a huge impact on patient's quality of life.

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