Strangulated femoral hernia presenting as parietal wall emphysema

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Surgical emphysema of abdominal and thoracic wall, along with features of intestinal obstruction, has not been reported as a complication of strangulated femoral hernia. We report a 31-year-old woman with such a presentation. [Indian J Gastroenterol 2005;24:218-219]

The diagnosis of strangulated femoral hernia is clinically challenging. We report a patient with strangulated hernia presenting with parietal emphysema.

A 31-year-old woman was admitted in hemodynamic shock, with history of pain in abdomen, vomiting and distension of the abdomen since 10 days. She also complained of progressively increasing swelling in the right lower abdomen for three days. On examination, the abdomen was distended and tender; bowel sounds were absent. The abdominal wall in the right iliac fossa was edematous, red, fluctuant and crepitant. The edema and crepitation extended from the groins to the axilla; this finding was confirmed on X-ray (Fig). There was no clinical evidence of groin hernia.

A clinical diagnosis of parietal wall necrotizing fasciitis with reflex paralytic ileus was made and the patient was taken up for drainage and debridement after resuscitation. A vertical incision was made in the right iliac fossa and feculent fluid with foul-smelling gas was drained from
Fig: X-ray abdomen showing parietal wall emphysema (arrows) with multiple air-fluid levels

the parietes. On extending the incision towards the groin, a perforated gangrenous gut loop could be seen in a necrotic femoral hernia sac. At laparotomy, a 7-cm-long perforated, mid ileal loop was found to be incarcerated through the femoral ring with no intra-peritoneal spillage. The gangrenous gut was delivered and resection-anastomosis was done. The femoral ring was repaired. Multiple vertical incisions were made in the abdominal wall for drainage of the parietes.

The postoperative period was satisfactory. Pus culture grew Bacteroides and Klebsiella pneumoniae, which were treated with appropriate antibiotics. Her abdominal wounds were stitched secondarily after 4 weeks.

Strangulation is often the first manifestation of femoral hernia and its diagnosis is often delayed due to mild or absent local signs. The most common physical sign is a tender lump at a previous hernial site. Abdominal signs may be missing especially in Richter’s hernia.

In untreated cases femoral hernia might lead to formation of local abscess followed by necrotizing fasciitis of the groin and thigh or enterocutaneous fistula. In the present case, subcutaneous groin infection by anaerobes became so fulminant that it manifested as surgical emphysema extending up to the axillae and involving almost the whole parietal wall. This complication masked the signs and symptoms of the underlying disease.

To our knowledge, such a presentation has not been previously reported. Awareness of this life-threatening condition can avoid delay in diagnosis and management of such cases.

References

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Late rejection after transabdominal pre-peritoneal inguinal repair: laparoscopic extraction of mesh

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We report a 29-year-old man who developed mesh rejection 3 years after laparoscopic transabdominal pre-peritoneal inguinal repair. The mesh, which was lying in a fluid cavity adherent to the urinary bladder and right iliac vessel, was removed laparoscopically. [Indian J Gastroenterol 2005;24:219-220]

Laparoscopic hernia repair has become a common surgery worldwide.1,2 There are sporadic case reports of mesh infection/rejection.

A 29-year-old man presented with dysuria, increased urine frequency, and hypogastric pain for the last 20 days. He had undergone laparoscopic transabdominal pre-peritoneal (TAPP) right inguinal hernia repair elsewhere three years ago. Urinalysis revealed 10-15 pus cells/hpf. Ultrasonography revealed crumpled mesh on the right side in a 6.6 cm x 6.4 cm collection indenting the right lateral wall and dome of the urinary bladder. Fluid was aspirated percutaneously under sonographic guidance and sent for culture and antibiotic sensitivity. No growth was noted. Cytoscopy showed indentation on the right wall and dome of the urinary bladder.

At laparoscopy, a large bulge was seen overlying the urinary bladder with omental adhesions, which was opened to reveal a cavity containing about 100 mL of serosanguinous fluid. Fluid was sucked with minimal contamination of the peritoneal cavity. A crumbled mesh (Fig) could be seen in the cavity, adherent to the bladder.