Case Snippets

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


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. 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 crumpled mesh (Fig) could be seen in the cavity, adherent to the bladder.
and right iliac vessel, fixed with prolene suture. The cavity was marsupialized. The mesh was removed with a combination of blunt and sharp dissection. The peritoneum was irrigated and drain was placed.

Postoperatively the patient had an uneventful recovery; the drain was removed on the third day and he was discharged on the fifth postoperative day.

Large series of laparoscopic hernia repair have been reported, with complication rates of 3.6%-7.6%.\(^1,2\) Late rejection of mesh, though rare, has been reported to occur as early as 15 days and up to three years later.\(^3,6\) In a series of 500 consecutive TAPP repairs, mesh rejection occurred in only 3 cases.\(^3\) If mesh rejection is not treated promptly, there is a danger of its migration, especially into the urinary bladder.\(^6\) In our case, the mesh produced a large indentation on the bladder.

In the presence of infection, the mesh can be removed through a suprapubic incision.\(^3,4,5\) However, when there is no infection, as in our case, a skillful operator may remove the mesh laparoscopically by a transabdominal pre-peritoneal approach. There has been only one prior report of laparoscopic removal of a mesh.\(^5\)

**References**


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**Primary gastric lymphoma and *Helicobacter pylori* infection with gastric amyloidosis**

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Primary gastric lymphoma, an uncommon gastric tumor caused by infection with *Helicobacter pylori*, is rarely associated with gastric amyloidosis. Chronic bacterial infection is known to cause amyloidosis. We report a 53-year-old man who had an antral and duodenal mass with narrowing and ulceration on endoscopy and CT scan; endoscopic biopsy revealed gastric amyloidosis. Rapid urease test and serology for *H. pylori* were positive. Histology of resected specimen of distal stomach revealed primary gastric lymphoma, amyloid deposits and spiral organisms suggestive of *H. pylori*. Rectal biopsy was negative for amyloid. He remained well on follow-up after surgery and eradication of *H. pylori*. [Indian J Gastroenterol 2005;24:220-221]

**Primary gastric lymphoma (PGL)** accounts for 1%-5% of malignant tumors of the stomach.\(^1\) Most PGL arise from the B cells of the mucosa-associated lymphoid tissue (MALT), commonly in association with chronic *Helicobacter pylori* infection.\(^3\) Amyloidosis is characterized by deposition of extracellular, dense, acellular, congophilic material secondary to chronic infection, inflammation or malignancy.\(^2,3\) Non-Hodgkin lymphomas, including extranodal MALToma, have been rarely reported to present with amyloidosis.\(^4,5,6\)

A 53-year old man presented with dyspepsia since one year, increasing since 3 months. He complained of anorexia and had lost 5 Kg weight during the last 3 months. He reported having occasional vomiting and melena for one week before presentation. He had received multiple courses of proton-pump inhibitors during the last year...