AMYAND'S HERNIA AS A SLIDING COMPONENT OF INGUINAL HERNIA

MUHAMMAD SHAMIM

ABSTRACT

The presence of vermiform appendix in inguinal hernia, referred to as Amyand's hernia, is rare occurring in about 1% of inguinal hernias. This is a report of Amyand's hernia, which presented as a sliding component along with enterocele in a right inguinal hernia in a 27-year-old male patient. Appendicectomy and hernioplasty were performed, with an uneventful postoperative recovery.

Key words *Amyand's hernia, Appendiceal sliding hernia, Inguinal hernia.*

INTRODUCTION:

Unusual sac contents can be found during operations of inguinal hernia. Ovary, fallopian tube, urinary bladder, colonic diverticula, Meckel's diverticulum (Littre's hernia) or persistent Mullerian duct syndrome have been reported.[1, 2] In 1735, Claudius Amyand first reported the presence of perforated appendicitis within an inguinal hernial sac. He performed transherniotomy appendicectomy, this being the first ever appendicectomy reported in literature.[3, 4] The incidence of vermiform appendix in inguinal hernia sac is approximately 1% of all inguinal hernias, where as appendiceal sliding inguinal hernia is even rarer.[5] In this case, transherniotomy appendicectomy and hernioplasty were performed which is not reported earlier.

CASE REPORT:

A 27 years old male came to out-patient department with a large size globular, complete, reducible, indirect right inguinal hernia. It was considered to be an enterocele as the gut sounds were audible over the swelling. The contents reduced with gurgling. The patient was otherwise fit, with no co-morbids. He was scheduled for an elective hernioplasty under spinal anaesthesia.

During the standard procedure of hernia at opening of hernial sac, the ileum was found free lying with vermiform appendix projecting as a sliding component (Figure I). Appendicectomy was done; it was 7.5 cm in length and appeared normal on histopathology. Herniotomy and hernioplasty was also done. Broad-spectrum perioperative antibiotic cover was provided. Postoperative recovery was uneventful and the patient was discharged on 3rd post-operative day with no complication reported at follow up.

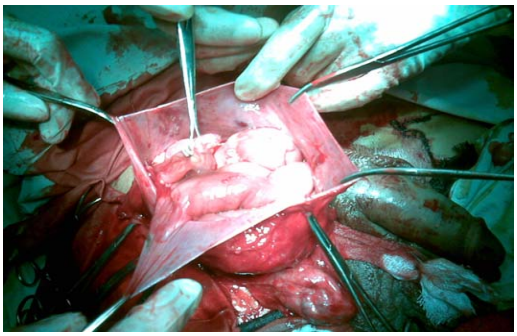

Fig-1. Appendix as a sliding component in hernia.

DISCUSSION:

Claudius Amyand while operating at St George's Hospital, on an 11-year-old boy with an inguinal hernia and a faecal fistula discharging in the groin found perforated appendicitis within the hernial sac. He performed appendicectomy; the patient recovered from faecal fistula but, the hernia recurred.[4] Appendix within the hernial sac can be complicated by acute appendicitis.[1, 6] Sliding appendiceal inguinal hernia is even rarer, with only 2 previous case reports in the literature.[5, 7] In this case, a normal looking appendix was found as a sliding component alongwith enterocele. Even in sliding variety, the base and tip of appendix can lie free within the hernia sac, as in this case, and thus by definition an Amyand's hernia.[8] There are reports of perforated appendicitis with peri-appendicular abscess in literature.[9] A better terminology may be Amyand's abscess.

Correspondence:
Muhammad Shamim
Department of Surgery
Fatima Hospital & Baqai Medical University
Karachi
Email: surgeon.shamim@gmail.com

Clinically, the presence of normal appendix within an inguinal hernia sac cannot be suspected, whereas a high index of suspicion is required for diagnosing acute appendicitis in inguinal hernia. Acute appendicitis in an inguinal hernia usually mimics an obstructed or strangulated inguinal hernia, or perforation of intestine within the hernia.[3, 6] However, a large size globular hernia should arouse suspicion of a sliding hernia and on the right side caecum, appendix or urinary bladder may form the sliding component (as this case turned out). The diagnosis is usually made intraoperatively on surgical exploration for inguinal hernia. A preoperative sonography or computed tomography scan of the abdomen could be helpful for diagnosis, but this is not routinely practiced after the clinical diagnosis.[7]

There is no standard protocol for the management of Amyand's hernia. Factors such as the presence of an inflamed appendix, contamination of the surgical field, patient age and anatomic features of the tissue are important determinants for appropriate surgery.[10] Normal appendix can be returned back to peritoneal cavity, or alternatively appendicectomy can be performed as in this case.[4] Hernioplasty (mesh repair) without appendicectomy is the favoured option in patients with a normal appendix.[8] Here hernioplastyand transherniotomy appendicectomy were performed without any postoperative complications, with broad-spectrum antibiotic support. However, in cases of appendicitis, transherniotomy appendectomy should be performed followed by herniorrhaphy (sutured repair).[3, 8, 9] The presence of pus or perforation is an absolute contraindication to hernioplasty.[3] The surgeons dealing with hernia should consider the possibility of Amyand's hernia, especially in suspected cases of obstructed or strangulated inguinal hernia or large globular hernia.

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