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General Surgery

AMYAND'S HERNIA: A CASE REPORT

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ABSTRACT Amyand's hernia is a rare and atypical hernia characterized by the herniation of the appendix into the inguinal sac. Preoperative diagnosis of Amyand's hernia is difficult, and is generally an incidental finding during surgery. Ultrasound and Computed Tomography may aid in diagnosis. We present at this article a 104 years old man who was admitted initially for strangulated right inguinal hernia. The patient underwent appendectomy with Bassini's repair and the post-operative course was uneventful.
The management of amyand's hernia is still controversial, and should consider both infectious risk and hernia recurrence.

KEYWORDS : Amyand's hernia, appendix, inguinal hernia, hernia.

INTRODUCTION

Amyand hernia is defined by the presence of an appendix, normal or inflamed, inside a hernial sac. It's a rare disease (0,4 – 0,6% of inguinal hernia). Its diagnosis is very difficult and often done in the per-operative period. The clinical picture may be asymptomatic or that of a strangulated hernia.

CASE PRESENTATION

Patient of 104 years, followed for a bilateral cataract, presenting for twenty years a right inguino-scrotal hernia reducible spontaneously, admitted to the emergencies for an inguinal swelling right, painful, irreducible, vomiting food, the whole evolving in a context of apyrexia with conservation of the general condition. The physical examination find a conscious, apyretic patient with an enormous right inguino-scrotal hernia strangled; the remainder of the clinical examination has no pathological findings. The ASP has shown air fluid level of small bowel (Fig 1). Surgical exploration revealed a strangulated right inguino-scrotal hernia with a suffering but viable ileo-coeco-appendicular content(Fig 2). Surgical management planned an appendectomy and the Bassini repair of
the hernia. No postoperative complications were seen.

DISCUSSION

Amyand hernia is a rare condition. Its incidence is 0.4 to 0.6% of inguinal hernias [1]. Management and progression are poorly understood given the limited number of cases reported in the literature. The physiopathology of HA is not well known.

Theories suggest that the mobility of the ascending colon and the coecum would facilitate the incarceration of the appendix in the hernial sac. Decrease of the blood perfusion by intermittent compression of the appendix or its meso would be responsible for the inflammatory phenomena and the formation of the adhesions which would explain the non-reducibility of the incarcerated segments [2].

The clinical presentation of an amyand hernia may be asymptomatic or that of a strangulated inguinal hernia[1]. On physical examination there is tenderness and swelling in the inguinal or inguinoscrotal region[3]. An inflammatory syndrome may occur depending on the course of acute appendicitis. Rarely necrotizing fasciitis complicates Amyand's hernia [1].

The diagnosis of AH is often discovered in per-operative. Abdominal ultrasound or CT may be useful for confirmation of diagnosis outside the emergency context [4]. AH cases were diagnosed and treated by laparoscopy[5].

The most common choice of treatment for Amyand's hernia is appendectomy via herniotomy, with primary hernia repair[6]. Lower midline laparotomy is recommended for cases of suspected perforation or pelvic abscess[7].

Prophylactic appendectomy, when the appendix appears normal, remains controversial. It is systematic for some authors to ovoid future complications [1,3,4]. While some argue for appendectomy only if the appendix is inflamed.

Most often, hernia repair is completed during primary surgery. Prosthetic mesh is typically contraindicated in patients with an inflamed or perforated appendix, due to the risk of wound and mesh infection. The treatment of choice in these cases is appendectomy using Bassini's repair[7].

CONCLUSION

Amyand's hernia is a rare condition. Its diagnosis is often made in per-operative. Its management seems complex and must take into consideration the infectious risk and the risk of hernia recurrence.

FIGURES

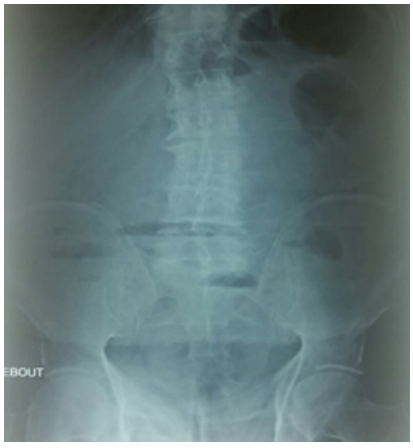

fig 1: ASP shows air fluid level of small bowel

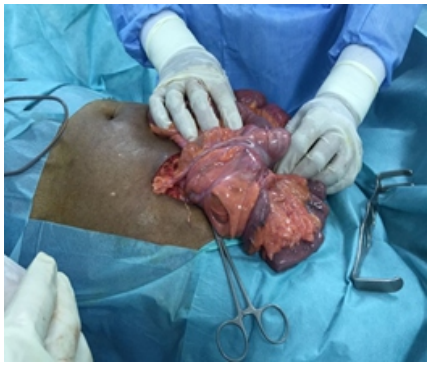

Fig 2: strangulated right inguino-scrotal hernia with a suffering but viable ileo-coeco-appendicular content

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