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Femoral Hernia in Male : A Rare Case Report

Medical Science

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ABSTRACT

A femoral hernia is a rare, which has been reported in less than 5% of all abdominal wall hernias, acquired condition with a female to male ratio of 4:1 and incidence increases with age. Diagnosing the nature of a lump in the groin is often difficult, especially in obese patients. Rarely, a strangulated femoral hernia can present atypically without abdominal or inguinal pain which can lead to delay in diagnosis of this dangerous condition. There are only few cases reported in the literature in which diagnosis femoral hernia in males were made clinically. We are reporting a rare case of femoral hernia in a male who has been operated with relevant review of literature.

Introduction :

A femoral hernia is the protrusion of a peritoneal sac which may contain fat, omentum or small bowel through the femoral ring into the femoral canal, posterior and inferior to the inguinal ligament. Although femoral hernias are less common than inguinal hernia, they are associated with higher rate of complication in the form of strangulation or incarceration thus increasing the morbidity and mortality. . As femoral hernias are typically small they can be missed on elective examination for groin swelling and sometimes can be mistaken for inguinal hernia due to difficulty in clinically distinguishing groin hernias

Due to greater prevalence of femoral hernia in females, whenever obstructed groin hernia is present in females, femoral hernia is the very important differential diagnosis and in males also this differential should be kept in mind as was the case with our patient and this can avoid the delay in time for surgery thus improving the prognosis of patient.

Case presentation:

A 75 year old male was admitted with complaints of swelling in right inguinal region since 1 year, on and off pain. Swelling which was small initially gradually progressed and attains present size and . Abdomen was soft, non-tender & bowel sounds were exaggerated. An irreducible firm tender mass was felt at right groin region & cough impulse was present.had history cough constipation since two days.

USG abdomen shows femoral hernia with mesentry and bowel loop as content, diagnosis made as obstructed right femoral hernia was made & he was taken up for emergency exploration of the inguinal region.

Bowel viability was checked and defect was repaired by approximating inguinal ligament to pectineal ligament using non-absorbable sutures. Postoperatively patient had uneventful recovery. Patient was discharged in satisfactory condition and is being regularly followed up in the out-patient department.

Figure 1 Shows right sided femoral hernia

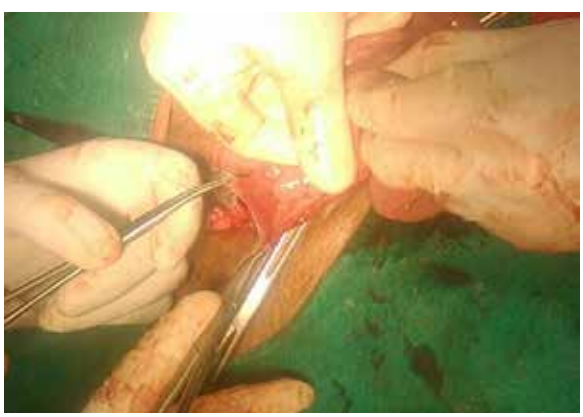

Figure 2 shows mesentry and bowel loop as content

Figure 3
defect was repaired by approximating inguinal ligament to pectineal ligament using non-absorbable sutures

Case discussion; Hernias in the groin may be either inguinal or, less commonly, femoral in origin. The anatomy of the femoral canal is that the anterior border is the inguinal ligament, the posterior border is the pectineal ligament, the medial border is the lacunar ligament and the lateral border is the femoral vein.

The majority of femoral hernia repairs (more than two thirds) are undertaken as emergency repairs. Femoral hernias account for only around 5% of all abdominal hernias: [2] Femoral herni-

as are more common in women than in men. The incidence is highest in middle-aged and elderly women, especially if parous. [3] They are rare in children and account for about 1% of groin hernias. Sex incidence is equal. Diagnosis is often difficult. [4] In elderly women the incidence of femoral hernia approaches that of inguinal hernia.

Presentation is as a lump in the groin, lateral and inferior to the pubic tubercle but a large hernia may bulge over the inguinal ligament and make differential diagnosis difficult. The hernia often appears or swells on coughing or straining and reduces in size or disappears when relaxed or supine. There may be a cough impulse. It may be possible to reduce the hernia. There may be associated lower abdominal pain if incarceration occurs. According to findings, the hernia may be classified as reducible, irreducible, obstructed or strangulated

Investigation Diagnosis is largely clinical, but is often missed due to lack of examination of the groin as part of abdominal assessment. Imaging techniques are helpful, with ultrasound scanning as first-line followed by CT scanning and MRI scanning. [5] Differential diagnosis The differentiation between inguinal and femoral hernia is not easy and doctors often get it wrong. Surgeons, including those in training, tend to be better than GPs but they too are far from perfect and so alternative criteria have been suggested: [6] Traditionally it is taught that an inguinal hernia will lie above and medially to the pubic tubercle whereas a femoral hernia lies laterally and below. This is not strictly true, as the internal ring is always lateral to the femoral canal and a small indirect inguinal hernia will therefore be lateral to the pubic tubercle. Also, a direct hernia will be lateral to or above the pubic tubercle. Abetter test might be to place the finger over the femoral canal for reducible hernias and then ask the patient to cough. This landmark is easily felt either by following the adductor longus tendon to below the inguinal ligament and then placing one's fingers anteriorly and laterally to the tendon or, alternatively, palpating the femoral artery and placing one's hand approximately a finger's breadth medially to it. When the patient coughs, a femoral hernia should remain reduced while an inguinal hernia will reappear as an obvious swelling. [6]

Complications The main concern with a hernia is strangulation. The risk of strangulation in a femoral hernia is 22% at 3 months and 45% at 21 months. [7] This is very much greater than for an inguinal hernia. Only 50% of patients are aware of the hernia before strangulation. Around 60% of patients present in the emergency situation. [6] Presentation If strangulation occurs, the lump will become red and tender as well as tense and irreducible. Other features include colicky abdominal pain, distension and vomiting, indicating a surgical emergency. Fluid and electrolyte imbalance must be corrected, followed swiftly by repair of the hernia. Failure to make a correct diagnosis is common. It is associated with a greater risk of needing bowel resection and a higher mortality. [8] Management In view of the high risk of strangulation, all femoral hernias should be repaired as an elective procedure, but as soon as possible. There is no place for a truss for a femoral hernia.

There are three surgical approaches that can be used to access the femoral sac, each named eponymously. There is a low approach (called Lockwood's), a trans-inguinal approach (called Lotheissen's) and a high approach (called McEvedy's). Each technique has the principle of dissection of the sac with reduction of its contents, followed by ligation of the sac and closure between the inguinal and pectineal ligaments. The procedure can be open or performed laparoscopically. The abdominal wall can be reinforced with either stitches or use of a mesh, the latter being more common. ACochrane review has reported that open mesh repair is associated with a reduced risk of recurrence. [9] In those who are unfit for general anaesthesia, local anaesthetic may be used. [10]

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