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FEMORAL HERNIA: CAUSE OF ACUTE INTESTINAL OBSTRUCTION IN VIRGIN ABDOMEN

General Surgery

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ABSTRACT

There are many causes of subacute intestinal obstruction ranging from most common like previous surgery scar mark to rare but important to remember and easily missed i.e obstructed femoral hernia. We report a case of 40 yr female admitted in Surgery department with c/o pain whole abdomen, vomiting and obstipation for 2 days and with no clinical diagnostic clue. CECT abdomen was done & cause of intestinal obstruction was found to be obstructed right femoral hernia.

KEYWORDS

Sub acute intestinal obstruction, obstructed femoral hernia

INTRODUCTION

We report a case of 40 yr female patient admitted in emergency with complaint of pain whole abdomen, vomiting and obstipation for 2 days.On examination abdomen was nontender and nondistended. Hernial sites on examination were normal, no h/o any previous surgery, no h/o drug intake, no h/o similar complaint in past. X ray showed multiple central air fluid levels. With no clinical diagnostic clue about cause of intestinal obstruction; we planned for CECT abdomen which showed right side obstructed femoral hernia (Fig 1). Emergency exploration was done with inguinal incision and small bowel was found to be present in hernia sac (Fig 2). Small intestine was viable and reduced in to the peritoneal cavity. Lacunar ligament incised & plug mesh repair was done. Post op patient had an uneventful recovery.

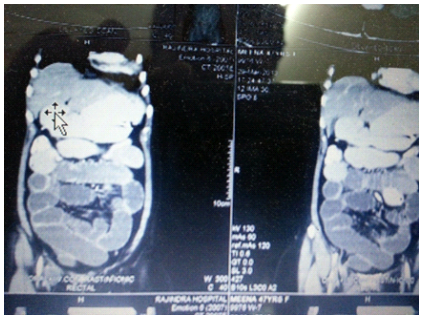

Fig 1– CT showing obstructed right femoral hernia

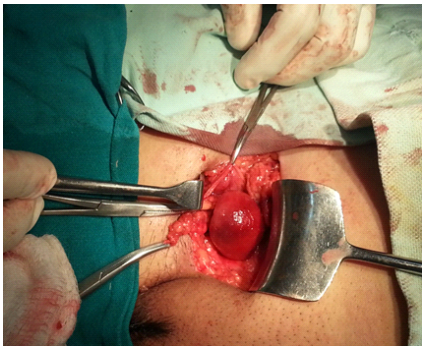

Fig 2 – showing small intestine as content of femoral hernia

DISCUSSION

A femoral hernia is the protrusion of a peritoneal sac through the femoral ring into the femoral canal, posterior and inferior to the inguinal ligament. The sac may contain preperitoneal fat, omentum, small bowel, or other structures. Femoral hernias account for a fifth of all groin hernias in females but less than 1% of groin hernias in males. The 40% of femoral hernias that present acutely are associated with a 10-fold increased risk of mortality. [1] In an emergency, patients may present with signs of bowel obstruction, which include colicky abdominal pain, vomiting, and abdominal distension. About a third of patients do not complain of symptoms directly attributable to a hernia and a groin lump is not always present. Inguinal hernias are usually reducible and above the inguinal ligament. Femoral hernias are often irreducible and below the inguinal ligament.[2] Although femoral hernias are less common than inguinal, they are associated with higher rates of acute complication. The cumulative probability of strangulation for femoral hernias is 22% three months after diagnosis, rising to 45% 21 months after diagnosis, whereas the probability of strangulation for an inguinal hernia is 3% and 4.5% respectively over the same time period.[3] However, femoral hernias tend to move superiorly to a position above the inguinal ligament, where they may be mistaken for an inguinal hernia. Differentiation of groin hernias on clinical grounds is therefore unreliable, irrespective of the experience of the examining doctor.[4] In patients presenting electively, only about 1% of groin hernias in males are likely to be femoral, whereas the likelihood in females is about 20%.[1] Ultrasonography, magnetic resonance imaging, and computed tomography (CT) have all been shown to be accurate in detecting and differentiating groin hernias. Ultrasonography is widely available, non-invasive, and highly accurate in differentiating inguinal from femoral hernia—with sensitivities and specificity of 100% being reported in two studies. [5, 6] Its accuracy is, however, operator dependent. Magnetic resonance imaging has been reported to be more accurate than ultrasonography in detecting inguinal hernia.[7] However, there is a lack of evidence for whether magnetic resonance imaging is better than ultrasonography in detecting and differentiating groin hernia. Therefore ultrasonography should be the first choice for electively investigating suspected groin hernia as it is more widely available, less costly, and accurate. CT scanning has been shown to be accurate in differentiating groin hernias. CT scanning should not be used electively for investigating suspected groin hernia. In the acute abdomen, however, consider CT as the first choice for investigating suspected small bowel obstruction in the presence of a negative clinical examination. [8]

CONCLUSION

- Obstructed femoral hernia should be kept in mind as d/d of intestinal obstruction even if hernial sites are found to be normal on examination .
- This condition should be kept in mind as cause of intestinal obstruction in virgin abdomen especially in females.

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