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OBSTRUCTED FEMORAL HERNIA: A CASE REPORT

General Surgery

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ABSTRACT

Femoral hernias are rare and acquired. Seen mostly in older age group with increased risk for complications such as obstruction and strangulation. In this case we have a 73 year old female with obstructed femoral hernia presented with features of intestinal obstruction. Patient underwent laparotomy with femoral hernia repair. Patient recovered and is doing well. Early clinical detection of Obstructed femoral hernia helps in reducing risk of morbidity and mortality.

KEYWORDS

Femoral hernia, intestinal obstruction, Emergency Laparotomy, Hernia repair

INTRODUCTION:

Femoral hernias are very uncommon and seen mostly in multiparous females. Femoral hernia occurs in the femoral canal medial to the femoral vessels.[1] Authors in the early 20th century advocated the theory that femoral hernia was congenital. It is currently largely discredited and acquired theory is widely accepted.[1]

Femoral hernias are less common than Inguinal hernia but they have the greatest risk of strangulation due to the narrow femoral canal and ring. Femoral hernia swelling can go unnoticed for a long period of time and it can also be a cause of small bowel obstruction hence, femoral hernia repair is mandatory.

Case Report:

A 73 year old nulliparous female presented with complains of pain abdomen since three days , not passing stools or flatus since 5days associated with faeculent vomiting 2-3 episodes per day. Patient also complains of abdominal distension since one day.

On physical examination, abdomen was found to be mildly distended with diffuse tenderness and guarding.On further examination Swelling was noted in the right side below the inguinal ligament of size 5x3cms irreducible, non tender with no signs of active inflammation.

Laboratory investigations were unremarkable. On imaging X-ray erect abdomen showed multiple air fluid levels with dilated small bowel loops. Contrast enhanced Computed tomography showed obstructed femoral hernia with small bowel loop obstruction at jejunum.

McEvedy's high approach was done using right paramedian incision. Femoral hernia with distal Jejunal loops as contents noted and reduced. Femoral hernia was approached by further blunt dissection between posterior rectus sheath and rectus muscle. Hernia sac was excised from the femoral canal. Hernia repair was done by dissecting in extra-peritoneal plane and repair was done by approximating inguinal ligament to coopers ligament and also closed intraabdominally with prolene sutures.

Bowel segment which was content of femoral hernia sac was noted to be healthy. Postoperative period was uneventful.

Figure 2: Femoral canal opening

DISCUSSION

Femoral hernias are protrusion of the intra abdominal contents through femoral canal which may contain either the bowel, fat or omentum. They make up for 2-8% of the groin hernias.[1] Most commonly seen between the ages 40-70 years.[1] With 4 to 5 times more preponderant in multiparous females. [1,3]

Around 60% of femoral hernias are found on the right side.[3] This preponderance of right sided femoral hernia is probably due to the anatomical position of the sigmoid colon.[2]

In elderly women like our case presenting with features of intestinal obstruction with no previous history of surgeries it is very important to thoroughly examine for groin swellings followed by radiological investigations such as Ultrasonography and CT scan.Any delay in diagnosis will lead to increased risk of morbidity and mortality in these patients.[4]

Femoral hernia can be repaired using either open or Laparoscopic approach. McEvedy's approach was preferred in the emergency setting such as ours as it allows better access for visualisation of intraabdominal contents to repair both bowel if involved and also repair hernia simultaneously [3]

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