CASE REPORT

SCROTAL ABDOMEN: A CASE REPORT

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ABSTRACT: Scrotal abdomen or Giant Inguino scrotal hernia, though an uncommon entity presents with operative dilemma as there are no standard surgical procedure. We present a case of giant inguinoscrotal hernia of a 49 yrs old male who had difficulty in performing his daily activities. Patient underwent mesh repair after reduction of content through inguinal and lower midline laprotomy with scotal reconstruction.

KEYWORDS: Giant inguino-scrotal hernia, mesh repair.

INTRODUCTION: Giant inguinoscrotal hernia are defined as, extending beyond the midpoint of thigh in standing position.¹ Such cases are due to neglect of symptoms by the patient till it affects the quality of life or present with complications. Operative intervention in such cases is associated with high mortality and post-operative complications.² We present a case of giant inguinoscrotal hernia, irreducible with no co morbidities.

CASE REPORT: A 49yrs Auto rickshaw driver presented to us with the complains of swelling in right groin since 20yrs which was initially reducible and since last 5yrs its not reducible. Patient had difficulty in walking and performing his daily activities. Patient is a smoker since 30yrs.

On examination: Right sided Inguinoscrotal swelling extending up to lower 1/3 of thigh in standing position, non-reducible, cough impulse present, penis buried, right side testis was atropic. (Fig. 1).

Preoperatively patient was advised to quit smoking and incentive spirometry exercises for 2weeks.

Patient was operated under general anesthesia, after unsuccessful attempts of reduction of contents through right inguinal incision, a lower midline laparotomy incision was made and contents were reduced after Omentectomy. Closure was done with no undue tension. Excessive scrotal skin excised and scrotum reconstructed. (Fig. 3).

Contents of the sac included omentum, small bowel, appendix, ceacum and transverse colon. (Fig. 2).

Patient was extubated after 24hrs, monitored in intensive care for 48hrs and discharged on POD7 without any complications. Follow up at 1month and 3month except for pain at operated site at times, no other complains or complications noted. (Fig. 4).

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Fig. 1

Fig. 2

Fig. 3

Fig. 4

DISCUSSION: Patient with giant inguinoscrotal hernia present with difficulty in walking, sitting and lying down, difficulty in voiding due to buried penis, or complications like scrotal skin ulceration, intestinal obstruction and torsion of testis.³

Contents of hernia sac commonly include small bowel, omentum, appendix, cecum and transverse colon, rarely include stomach, sigmoid colon, urinary bladder, kidney and ureter.⁴

In general the problems encountered during and post-surgery are:

1. Difficulty in reduction of contents.
2. Raised abdominal pressure leading to cardiorespiratory distress following reduction.
3. High recurrence rate due to large defect.
4. Excessive scrotal skin.⁵

Long standing giant inguinoscrotal hernia or scrotal abdomen causes decrease in abdomen capacity and adhesion between the contents and contents and sac which make the surgery

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complicated and reduction of contents produce respiratory compromise. The problem of reduction and post reduction complication can be minimized by either debulking of contents or increasing the abdominal capacity or creating midline defects.

Extensive bowel resections, for example total or hemicolectomy as well as omentectomy and even small bowel resections have been described.³ Progressive, artificially induced pneumoperitoneum has been attempted, but usually causes enlargement of the hernia sac, rather than the abdominal cavity and is therefore not very effective. Increasing the abdominal capacity by creating midline defects and closing it with component separation technique⁶ or inguinoscrotal flap as described by Merret et al,⁷ or tensor lata flap as reported by Mehendale et al.⁸

Preoperative chest physiotherapy and delayed extubation to overcome the respiratory distress which complicates the post-operative period due to rise of intra-abdominal pressure secondary to reduction. Bladder pressure monitoring to check for the rise in intraabdominal pressure during post-operative period.⁵

There is high chance of recurrence due to large defect which can be managed by mesh repair wherever possible. Excision of spermatic cord and testis has been practiced by some to avoid reconstruction of inguinal canal and potential chance for recurrence.⁹

Excessive scrotal skin can be excised if the patient prefers for cosmetic reasons or can be left behind to allow dartos to contract and retract over a period of time. Advantage of leaving behind scrotal skin that if patient develops respiratory complication in spite of above mentioned procedures then contents can be reduced back to scrotum. Scrotal drain to be placed insitu and firm compression bandage to prevent scrotal hematoma formation, drain can be removed on second post-operative day.⁷

CONCLUSION: Giant inguinoscrotal hernia though uncommon surgical problem, management of which is challenging with fatal complications, can be dealt with adequate preoperative preparation, debulking of contents if necessary, mesh repair to prevent recurrence and postoperative monitoring to raised intrabdominal pressure and its complications.

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