



Rare case of Femoral hernia- Diagnostic dilemma

Dr. Abhishek Kumar¹, Dr. Vijay Pal², Dr. Ashok Kumar Gupta³

¹Student, National Institute of Medical Sciences & Research, Jaipur, Rajasthan

²Assistant Professor, National Institute of Medical Sciences & Research, Jaipur, Rajasthan

³Professor, National Institute of Medical Sciences & Research, Jaipur, Rajasthan

ABSTRACT

Femoral hernias are a relatively uncommon, accounting for less than 5% of all hernias with a female predisposition, likely due to the wider pelvis or wider femoral canal. The male to female ratio is 1: 4 and increases with age. Presentation of this hernia can be varied from asymptomatic to incarcerated groin lump. Diagnosing femoral hernias preoperatively is challenging due to the resemblance to an inguinal hernia. Diagnosing the nature of a lump in the groin is often difficult and a delay in diagnosis may occur, especially because an obstructed or strangulated femoral hernia may not always typically present with abdominal or inguinal pain. Femoral hernias may have an abnormal presentation and may misguide the diagnosis. A proper examination and histopathology reporting should be done for confirmation. Hence, one should have a high index of suspicion in these cases as they can have varied presentation preoperatively.

Keywords: Femoral hernia, Atypical presentation, Strangulated Femoral hernia

1. INTRODUCTION

We present the case of a 73-year female Asthmatic patient she was taking Salbutamol 4mg daily for 4 years and also had hypertension since 1 year for which she had taking medicines irregularly. The patient came to National Institute of Medical Sciences & Research, Jaipur in OPD.

A femoral hernia is uncommon in all groin hernias. However, presentation of a femoral hernia has varied symptoms. The optimal management of a femoral hernia is surgical. It is performed urgently in patients who present with acute incarceration or strangulation. For patients with no complications, the optimal timing of repair (watchful waiting versus early elective repair) and the optimal surgical technique are controversial. In patients with a newly diagnosed femoral hernia, elective surgical repair is recommended, rather than watchful waiting, regardless of the patient's sex and symptoms, as they are associated with a high risk of complications.

2. CASE REPORT

A 73 old female presented to our OPD with complain of swelling in left groin since 4 days without any other symptoms. The patient had no urinary symptoms and had normal bowel action on the morning of admission. The patient had well-controlled asthma by medication but her blood pressure was on the higher side as the patient was taking medication irregularly.

The vital examination was normal. Abdominal examination on inspection, there was single round swelling of size 5cm * 4cm situated 2-3 cm above the left inguinal ligament, non-pulsatile, no cough impulse present and skin over the swelling was normal. Local temperature was not raised and there was no tenderness. The size of swelling was 5cms * 4cms * 3cms having a smooth surface and well-defined margins. The consistency was firm with no fluid thrill, impulse on coughing absent and swelling was nonreducible, non-compressible, and non-pulsatile. The swelling was nonadherent to skin but there were restricted movements at the base of swelling. On percussion, there was a dull note and there was no sound on auscultation. On the next day on examination the swelling was tense and has grown in its size and has become 6 * 5 * 4 cms still there is no symptoms or tenderness over the swelling and no features of obstruction or strangulation and bowel bladder habits were normal and swelling migrated over inguinal ligament, so the patient was planned for exploration under spinal anesthesia. The inguinal approach was used and the incision was given over the swelling. Intraoperative findings revealed 6*5*4cms hemorrhagic firm mass of dark brown in color and after opening thickened sac over the swelling. (Pic-1) mass of size 5*4*3cms was excised out and cut open vertically shows closed viscus e.g. colon like morphology, so decision was taken for exploration of the abdominal cavity to rule out any strangulated intestine. In spite of the severe side effects of general anesthesia in benefit of doubt general anesthesia was given and a lower midline incision was taken and the abdominal cavity was open. The content of femoral canal was pushed back in the abdominal cavity which was pedunculated extra luminal continuity from the antimesenteric border from sigmoid colon which was excised out and extra-abdominal mass as well as intra-abdominal mass was sent for histopathological examination. (Pic-2) The femoral canal was closed with 2-0 proline round body. Laparotomy incision and the inguinal incision was closed with Ehtilon 2-0. Patient has a remarkable recovery in post-op and discharged on 7th day.

3. DISCUSSION

A femoral hernia is an elusive condition that despite having life-threatening complications are often undiagnosed in asymptomatic patients. The diagnosis of a strangulated femoral hernia still presents a challenge to all clinicians. In this case, the first diagnosis was made as inguinal lymphadenopathy as of location and consistency and USG was advised which reveals multiple lymph nodes in the left inguinal region and there was also a small defect in inguinal region with herniation of mass with the accidental finding of cholelithiasis.

Femoral hernias are commonly missed or misdiagnosed as less serious conditions, leaving surgeons to deal with their complications in the acute setting, where mortality has been found to be 10fold [6, 7, 8]. Differential diagnosis of a femoral hernia includes lymphadenopathy, saphenous vein varicosity, pseudo hernia, femoral artery pseudoaneurysm, soft tissue masses. The hernia sac commonly consists of small bowel or momentum, but uncommon cases have been reported, where the herniating structures were caecum, appendix, colon, Meckel's diverticulum, ovaries, testes, stomach and kidneys [8].

According to Dahlstrand et. al, who published the largest series of femoral hernia repairs to date [6], out of 3, 980 femoral hernia repairs 1430 (35.9%) were emergencies, compared to just 5.4% for inguinal cases. Furthermore, 22.7% of the emergency procedures for femoral hernias required bowel resection compared to 5.4% for inguinal hernias, whereas that percentage of bowel resection in elective femoral hernia repairs was only 0.6%. Dahlstrand et al also demonstrated that women were more likely than men to require surgery for femoral hernias (5:3 ratio). The risk for emergency surgery for women was also significantly higher (40.6 vs. 28.1%). So, in this case despite clinical misdiagnosis case is an atypical asymptomatic presentation of a femoral hernia which contains pseudo polyp from the antimesenteric border of sigmoid colon which is a rare case.



Fig. 1: Excised specimen



Fig. 2: Arrow showing antimesentric border of sigmoid colon having Pedunculated mass (excised)

4. REFERENCES

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