CLINICAL IMAGE

Rare Case of Inguinal Hernia in a Female Patient

Liaqat Ahmad Malik, M.S.¹ Ajaz Ahmad Malik, M.S.² Parvez Mohi u din Dar M.S.³

^{1,3} Senior Residents, ² Professor Department of General & Minimal Invasive Surgery SKIMS

Inguinal hernia in females is relatively uncommon as compared to males. It is interesting to note that 1 male in 5 and 1 female in 50 will eventually develop inguinal hernia in lifetime. The incidence of inguinal hernia in females is 1.9%, the ratio of boys to girls being 6:1. The incidence of indirect hernia relates to congenital weakness at the internal abdominal ring. The sac is formed by the unobliterated portion of the prenatal peritoneal invagination of the canal of Nuck that runs along and partly covers the round ligament.

An elderly female, age 75 years was referred to our hospital as a case of left sided irreducible inguinal hernia. Patient was a known case of rheumatic heart disease (severe MS with MR with TR) with ejection fraction of 55%. Patient was on furosemide and metoprolol. Patient was having history of constipation for 4 days and mild pain lower abdomen. All investigations were within normal limit and patient was afebrile. Abdomen was soft and non-distended. There was mild tenderness over right inguinal region and a

soft boggy swelling was palpable. It was non-reducible.

Patient was high risk candidate for surgery and cardiologist advised surgery under general anesthesia with postoperative ventilatory support standby. Keeping in view the low performance score of patient, it was decided to explore patient under local anesthesia and she was taken up for emergency surgery under local anesthesia. On exploration, there was necrosed omentum & a loop of small intestine in the indirect sac. The exposed sac was opened and necrosed omentum excised and intestinal loop was grasped with a Babcock forceps. The bowel loop was examined for viability, external ring divided and internal oblique fibres laterally incised to allow reduction of the hernial contents. The sac was ligated at the base and rest of the sac was removed. Defect was approximated with prolene sutures & wound was closed back in layers without drain. Patient had an uneventful recovery and was discharged on 5th postoperative day.

Fig. (1) Cut section of sac with visualized necrosed omentum & small bowel loop.

Correspondence

Dr. Liaqat Ahmad Malik, M.S.
Senior Resident, Department of General & Minimal
Access Surgery SKIMS
Email: wass41@gmail.com