

CASE REPORT

Right Sided Obstructed Femoral Hernia Causing Small Bowel Obstruction

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ABSTRACT

We describe the case of 55 year female with swelling and pain in right inguinal region associated with abdominal distension and vomiting. Abdominal x-rays (upright) were performed which was indicative of small bowel obstruction. Ultrasound was suggestive of Right sided inguinal region showing gap defect with herniation of small bowel and omentum non reducible and absence of cough impulse with dilated small bowel. S/O Right sided inguinal hernia with developing small bowel obstruction. CECT Abdomen was showing evidence of dilatation of small bowel loop with air fluid levels within it with max diameter of 32mm. S/O Right sided inguinal hernia 19mm gap defect with small bowel obstruction

**Key words:** Femoral Hernia, Small Bowel Obstruction, Emergency lapotomy, Pre Peritoneal Meshplasty.

INTRODUCTION

Femoral hernias are elusive conditions that despite having life-threatening complications are often undiagnosed in asymptomatic patients. They are less common than inguinal hernias and occur more frequently in females. Anatomically, they represent herniations of the peritoneal sac through the femoral ring into the femoral canal, lying postero-inferiorly to the inguinal ligament. The hernia sac commonly contains small bowel or omentum, but uncommon cases have been reported, where the herniating structures were caecum, appendix, colon, Meckel's diverticulum, ovaries, testes, stomach and kidneys.

CASE HISTORY

A 55 years old hindu female patient named Jinabai Danabhai working as a labourer coming from a lower socioeconomic class residing at Wankaner was admitted in P.D.U. Hospital with the complaint of swelling and pain in the right inguinal region. Patient was relatively

asymptomatic before 1 year then patient observed small swelling over right inguinal region. Initially swelling was of small size then gradually its size increased since last 9 months then swelling become painful suddenly and vomiting with distension of abdomen occurred. All baseline blood investigations were normal. Flat and upright abdominal x-rays were performed which did not reveal any free air under the diaphragm. However the pattern of bowel gas was indicative of small bowel obstruction. Ultrasound was suggestive of Right sided inguinal region showing gap defect with herniation of small bowel and omentum non reducible and absence of cough impulse with dilated small bowel. S/O Right sided inguinal hernia with developing small bowel obstruction. CECT Abdomen was showing evidence of dilatation of small bowel loop with air fluid levels within it with max diameter of 32mm. S/O Right sided inguinal hernia 19mm gap defect with small bowel obstruction. So, emergency exploration and reduction of obstructed femoral hernia and pre peritoneal prolene meshplasty done with size (6\*11) cms. Post operative period was uneventful. Patient was started orally on 3<sup>rd</sup> post op day and discharged on 4<sup>th</sup> post op day with no complications on follow up examination.

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### DISCUSSION

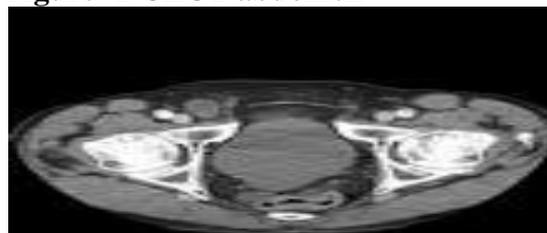
A femoral hernia is an extension of a viscous in the course of the femoral canal and exit via the saphenous opening due to a defect in the femoral ring. It is the third commonest hernia and twenty percent happening in women versus 5% in men. This hernia is more common on the right side of multi-parous old women. The femoral ring is bordered anteriorly by the inguinal ligament, posteriorly by the iliopectineal ligament, medially by the lacunar ligament, and laterally by the femoral vessels. The narrow femoral canal and rigid femoral ring are the main cause of bowel incarceration, strangulation and bowel resection which has been shown to have increased mortality and morbidity . The etiology is a controversial topic due to lack of data in condition of congenital versus acquired hypothesis. The acquired theory is widely accepted with a general clarification of increased intra-abdominal pressure from chronic bronchitis and constipation leading to stretching of the femoral ring from a dilated femoral vein . Clinical manifestation possibly the sensation of a bulge in the groin. Colicky abdominal pain and vomiting may persevere due to incarceration and obstruction or strangulation of small bowel. On examination, the hernia can be recognized below and lateral to the pubic tubercle; it may be generally irreducible and may be tender . A femoral hernia needs to be distinguished clinically from other groin lump for example inguinal hernia, saphenavaricocel, groin lymphadenopathy, lipoma, femoral artery aneurysm, and psoas muscle abscess. Generally diagnosis is clinically; but, imaging techniques such as ultrasound, CT, MRI or diagnostic laparoscopy may be useful. The protruded viscous is strangulated and undergoes a tissue necrosis in the femoral hernias more than other types of hernia. When diagnosed, femoral hernias should be electively repaired as soon as possible. The golden standard operative management to repair the defect are using either the McEvedy operation or totally extraperitoneal approach (TEP) or the

transabdominalpreperitoneal approach (TAPP). Femoral hernia is a rare cause of gastrointestinal obstruction and is at high risk of strangulation due to the narrow femoral canal and femoral ring

### CONCLUSION

Obstructed femoral hernia of the small bowel is rare and the general surgeon should be familiar with femoral hernia as a bowel obstruction source.

### Figure- 1 CECT abdomen



### Figure-2a Intra operative findings



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