HERNIA UTERI INGUINALIS IN THE MALE

by

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The entity of hernia uteri inguinalis is not commonly encountered. So far only 41 such cases have been reported in the world literature. Owing to its rarity, it was thought to be worth while presenting this case.

CASE REPORT

S. S., a 27 year old male patient, was admitted in the surgical ward of K.E.M. Hospital, Bombay, on 28th March 1967, with a complaint of a painful swelling in the right inguinal region. The swelling was first noticed at the age of 9 years, but used to disappear on lying down. On admission, diagnosis of obstructed right inguinal hernia was made and the patient was taken up for operation.

At operation, the hernial sac was found to contain structures resembling uterus. During manipulations, blood pressure fell and the hypotension persisted in spite of treatment and therefore a decision was taken to relieve the obstruction to hernial sac without dissecting the organs involved which would have required careful and prolonged dissection. The patient was seen at Endocrine Clinic on 10-4-1967. The clinical findings were as follows:

The patient was a well-built and nourished individual with height 154 cms. and weight 52 kg. The distribution of body hair was masculine. There was no gynaecomastia. Local examination revealed a well-developed phallus with a penile urethra. The scrotum showed normal rugosity and contained a tense mass. On the right side, there was an inguinal hernia, which was partially reducible. After reducing the hernia, the vas could be felt on the right side. On the left side, the vas could not be felt. Examination of other systems did not reveal any abnormality. On rectal examination, normal prostate could be palpated.

On repeated examination, the patient was found to be azoospermic. Buccal smear was taken and the patient was found to be chromatin negative.

The patient was explored again, right inguinal canal was exposed by a right transverse inguinal incision. The contents of the hernia were drawn out through the right inguinal canal and it was noted that the scrotum was empty. It was a sliding hernia, which contained a uterus with cervix, both gonads, broad ligament and right spermatic cord, forming the posterior boundary of an otherwise well developed hernial sac (congenital). The congenital sac was transfixed at the level of the internal inguinal ring and excised. The gonads were opened along the long axis. They resembled testes and no ovarian tissue was evident to naked eye. The left gonad was attached to the back of the uterus in the position of the ovary. There was no structure resembling spermatic cord, hence the right inguinal incision was extended to the left side and left inguinal canal was opened. It was found to be empty. except some

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rudimentary veins resembling spermatic cord veins emerging near the internal ring which merged into the lateral wall.

For the repair of hernia, the removal of uterus and left gonad was thought to be necessary. Because of the close association of right spermatic cord with the uterus it was found mandatory to remove the right gonad. Thus a total extirpation of all the structures herniating was performed. This was followed by Bassini's herniorrhaphy on the right side. The incision on the left inguinal canal was closed. The patient had a smooth post-operative convalescence and was discharged on the 6th day. He was referred to plastic surgery unit for acrilic prosthesis.

Specimen:

Gross pathology:—The specimen consisted of a uterus of dimensions 3″ x 2″ x 1″. The left broad ligament was well-developed showing uterine vessels. The right broad ligament was poorly developed. Both gonads had the shape and size of normal testes. The left gonad was attached to the uterus by utero-ovarian ligament. The right gonad was accompanied by a well-developed epididymis and vas, which coursed upwards towards the position of the fallopian tube and then along the right border of the uterus inside the myometrium upto the cervix. Throughout its entire course, the vas showed a well-defined lumen. There was no structure, resembling a vas or fallopian tube on the left side. There were only a few strands of fibrous tissue. As the dissection was not carried out towards the perineum, it is difficult to say, how much of vagina was present. The hysterectomy was done near the cervix.

Histology:

Left gonad: The tunica albuginea was thickened. There was peritubular fibrosis. The tubules were lined with single layer of epithelium without any further differentiation. The tubules were hyalinised. The tubules showed preponderance of Sertoli cells. The Leydig cells were fewer in number as compared to cryptorchid testes. In one part of the section there were sheets of cells, separated by connective tissue septa. These cells appeared embryonic in nature with a vacuolated cytoplasm and vesicular nuclei.

Right gonad: The appearance was similar to left, but with very few germ cells. Right epididymis showed normal structures. The tubules were rather compressed together. Vas showed a well-developed lumen and epithelium but the folds were less than normal.

Uterus: The uterus showed normal myometrium. The endometrium was scanty but with few inactive glands.

Cervix: The section through the cervix showed two structures resembling vas on either side of the cavity in the muscle wall.

Discussion

McCahey (1938) classifies male pseudohermaphrodites into those with Mullerian derivatives and those without Mullerian derivatives. Male pseudohermaphroditism is characterised by the presence of female generative organs in persons who have gonads exclusively of testicular tissue. Thus, in addition to Woolfian duct system, there is development of Mullerian duct system.

In our patient, no ovarian tissue was detected even on doing serial sections. Both the gonads contained testicular tissue. However, there were some undifferentiated cells, detected in the left gonad.

According to Overzier (1963), inguinal herniae are common in pseudohermaphrodites just as in true hermaphrodites. They are present in about one-third cases of pseudohermaphrodites. Nilson classifies these cases of hernia into 3 groups. In the first, the uterus and the adnexae on both sides are contained in the hernia. In the second, the uterus and adnexae on one side are contained in the hernia. The

adnexae on the other side remain in the peritoneal cavity. The third group includes those cases in which a unicornuate uterus or one horn of a uterus didelphys with its corresponding adnexae is present in the hernia.

Had it not been for the hernia, this case could have been easily missed. Nilson, however, claims to diagnose hernia uteri pre-operatively by bimanual palpation of the mass, the condition having been previously suspected, on noting the absence of a testis on the side opposite to that of hernia.

The other clinical features are just like those encountered in our patient. The position and structure of gonads, epididymis, vas in our case agree with those in a typical case of male pseudohermaphrodite. In our case, the vas was not dissected down to perineum owing to difficult dissection, but it has been reported that the vas may proceed in a tortuous fashion close to the vagina, forming pseudo-seminal vesicles and finally opens separately from it into the urogenital sinus. The prostate surrounds the urethra and the proximal part of the vagina. The patients in this group are generally considered genetically male (Kozoll, 1942).

This condition, according to McCahey (1938) is said to have resulted because of insufficient testicular influence to suppress the Mullerian ducts. The treatment consists of removal of Mullerian duct system in the hernial sac, excising the hernial sac, repairing the hernia and replacing the gonad, if possible, in the scrotum. If the testes cannot be brought down in the scrotum, orchidectomy is advised (Smith, 1963).

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