

Femoral Hernia with a Rare Content

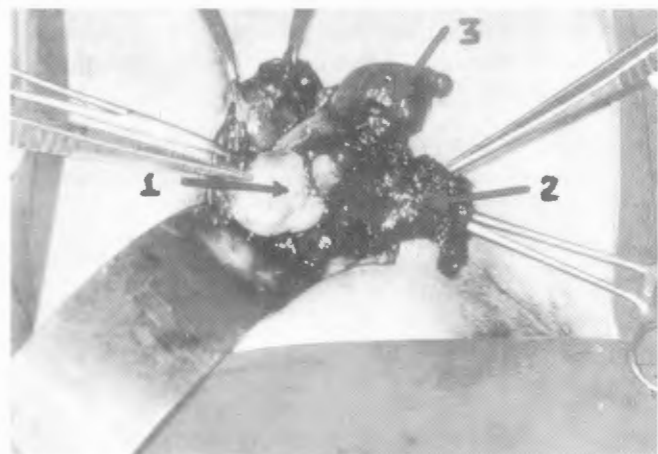
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Case Report

A forty-nine year old multiparous woman presented to emergency department with history of reducible swelling in the left groin for past three years, which had suddenly increased in size developing pain and irreducibility for preceding two days. General examination was within normal limits. Local examination revealed a large retort shaped, tender, irreducible swelling in the left groin, both above and below the groin crease without any cough impulse. Diagnosis of strangulated left femoral hernia was made. Emergency inguinal exploration revealed congested, edematous but viable ovary, fallopian tube with its fimbrial end and a 2X2cm parafimbrial cyst as the contents of femoral hernia (Photograph 1). She underwent Lotheisen's operation after reducing the contents. These contents have not been reported as the contents of femoral hernia, in the literature we searched.



Photograph 1 : Femoral hernial sac with its contents of (1) ovary (2) fallopian tube with its fimbrial end and (3) parafimbrial cyst.

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Discussion

Femoral hernias are relatively rare in India and may contain abdominal contents or extraperitoneal fat^{1,2,3}. They are four times more common in women than in men³. In one series of femoral hernias, almost half of the male patients and nine percent of female patients had an associated inguinal hernia¹. Femoral hernia should be considered as the third variety of inguinal hernia, as the defect that allows a femoral hernia to develop is as truly inguinal as in the other two types of inguinal hernias⁴. Femoral hernias are never congenital and their etiology is unclear, although elevated intra abdominal pressure and / or laxity of groin tissues is implicated¹. They are most common in parous women as in this patient and their incidence increases with advancing age, especially in those with weight loss, chronic cough or constipation^{1,3}.

Femoral hernias may be symptomatic or asymptomatic. Due to the rather rigid environs of the femoral canal, they become strangulated far more frequently than other types of hernias^{2,3}. More than 35% of them become strangulated sooner or later, if they are not operated upon².

Femoral hernias should not be treated conservatively as there is a high incidence of strangulation³. Emergency repair is 10 times more common than elective operation as in this patient³. The ideal surgical approach to femoral hernia remains controversial. A number of approaches are available for repair and they are best described with regard to technical approach and the author⁵. Broadly, they are grouped as either the upper approaches or the lower approaches⁵. The upper approaches are again subgrouped either as anterior or posterior approaches⁵. The requisites for success in the repair are complete

excision of the sac, exclusion of pre-peritoneal fat from the repair, use of non-absorbable suture materials, and use of Cooper's ligament in the repair as it offers strong support for sutures.

The lower approach is suitable only for the uncomplicated small elective hernia in a thin patient³. This is particularly applicable to women because they rarely have associated inguinal hernias and their inguinal canal floor is strong and seldom requires repair and is also indicated in men with femoral hernias after repair of inguinal hernias. Lower approach cannot be used when there is need for intestinal resection. The upper approach is recommended for repair of strangulated femoral hernias and when a concomitant inguinal hernia needs to be repaired^{1, 3}. The upper approach is obligatory when a femoral hernia is diagnosed as inguinal hernia³. Among the upper approaches, the pre-peritoneal approach has all the advantages of the trans-inguinal

approach, and gives better access without weakening the inguinal canal³.

References

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