

A Rare Combination of Left Sided Amyand's and Richter's Hernia

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Abstract

Inguinal hernias are one of the most common surgically managed conditions. Variations in anatomical defect and the content of the hernial sac are very common and so are the clinical presentations. We present a combination of left sided Amyand's hernia with strangulated Richter's hernia of the caecum. This is first case of Amyand's hernia with necrotic patch on caecum. The presentation and related literature is discussed.

Introduction

Appendix is encountered in inguinal hernias in about 1% of cases. Claudius Amyand, British surgeon in 1736, discovered a type of hernia, which was tender in an 11-year-old boy, which had a perforated appendix within an inguinal hernia on the right side. Thus the presence of an appendix in an inguinal hernia was known as 'Amyand's hernia'.¹ The term Amyand's hernia is used in varying situations, authors have referred to Amyand's hernia as the occurrence of an inflamed or normal appendix within an indirect inguinal hernia.^{2,3} There are few case reports where presence of appendix in left sided inguinal hernia have been documented.³ Inflamed appendix present in left inguinal hernia is relatively rare.³

The earliest known reported case of Richter's hernia occurred in 1598 and was described by Fabricius Hildanus. The first scientific description of this particular hernia was given by August Gottlob Richter in 1778 where in a small circumference of the bowel

gets strangulated in the hernial sac.⁴

There is only one reported case of Right sided Amyand's and Richter's hernia, complicated by necrotising fasciitis in literature.⁵

We report a rare combination of left sided Amyand's hernia and Richter's hernia of the caecum.

Case Report

A 34 year old male patient presented with an inguinal swelling on left side for 6 months. The swelling was initially reducible, however it became irreducible 2 days prior to presentation. He gave history of pain since 1 day with no bladder or bowel complaints. On examination patient had tachycardia and an irreducible, tender left inguinoscrotal swelling which suggested strangulated hernia.

Patient underwent emergency exploration through left inguinoscrotal incision. Intra-operative finding revealed vermiform appendix and a patch of gangrenous wall of the caecum stuck in the neck of the sac. The segment of caecal wall which was impacted in the deep inguinal ring was gangrenous where as the remaining part of the caecum was hyperaemic (Fig. 1), bowel proximal and distal to this was normal, confirming it to be an Amyand's hernia with Richter's hernia. There was a long lateral fold of the peritoneum, which was responsible for increased mobility of the caecum, as a result it got herniated in the left inguinal region.

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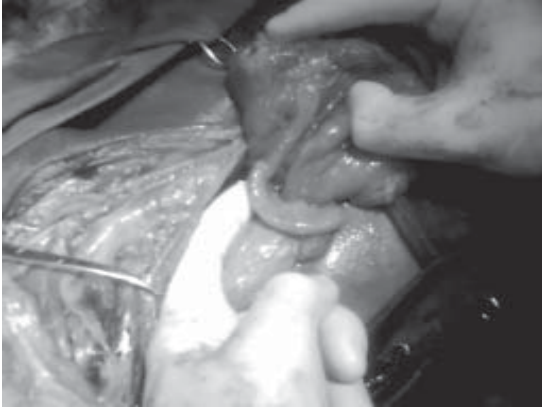


Fig. 1 : Intra-operative finding left sided inguinal hernial sac with appendix and caecum with gangrenous patch.

Decision was taken to explore the abdomen through a midline incision, to perform the appropriate resection anastomosis and to rule out malrotation of bowel and situs invertus. Quartercolectomy with ileo-ascending colon anastomosis was performed.

Left inguinal hernia repair was done without using synthetic mesh. Postoperative recovery was uneventful. Follow-up of one year has shown patient to be symptom free.

Discussion

The content of hernial sac is never thought about in an inguinal hernia, as sac usually contains the omentum or small bowel. However, contents can be surprising, such as bladder (sliding hernia), Meckel's diverticulum (Littre's hernia), Appendix (Amyand's hernia).^{3,5} or a portion of the circumference of the intestine (Richter's hernia).

Amyand's hernia is normally present on right side. Left sided Amyand's hernia is very rare and usually associated with situs invertus, intestinal malrotation or a mobile caecum.³

It is rare to be able to diagnose Amyand's hernia pre-operatively and rarest to diagnose combination of ipsilateral Amyand's and Richter's hernia. Pre-operative computed tomography (CT scan) of the abdomen may be helpful but we routinely do not perform CT scans for an irreducible hernias.

The presence of a normal appendix in hernial sac does not require appendectomy whereas acute appendicitis necessitates appendectomy.³

The management of combination of ipsilateral Amyand's and Richter's hernia depends on the situation and condition of the tissues as in this case we had to do resection of the gangrenous caecum and ileo-ascending anastomosis i.e. quartercolectomy through separate midline incision. The absence of obstructive symptoms has delayed the patient's presentation, this is similar to patients of Richter's hernia who present late.⁵

Early operative intervention is the mainstay of successful management of Richter's hernia and awareness of this disease and its misleading clinical presentation is of utmost importance.

References

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