

## **Giant Scrotal Hernia in an Elderly Man**

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### **ABSTRACT**

*Giant inguinoscrotal hernias are troublesome for surgeons, although less common in recent years. In this study, we report a patient aged 76 years with giant inguinoscrotal hernia.*

**Key words:** Hernia, Scrotal hernia, Surgery

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### **ÖZET**

#### **Yaşlı Hastada Dev Skrotal Herni**

*Dev inguinokrotal herniler son yıllarda daha az görülsede, cerrahlar için halen bir sorundur. Bu çalışmada, 76 yaşında dev inguinokrotal fıtığı olan bir hasta sunulmuştur.*

**Anahtar kelimeler:** Fıtık, Skrotal fıtık, Cerrahi

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## INTRODUCTION

Surgical repair of giant inguinoscrotal hernias is often complicated. The physiological changes associated with the loss of domain can pose a risk for increased complications during surgery and the post-operative period<sup>[1,2]</sup>. In this report, we describe our surgical management of a giant inguinoscrotal hernia to highlight the specific difficulties encountered in the treatment of these hernias.

## CASE REPORT

A 76-year-old man presented with a three-decade history of a progressively enlarging left inguinoscrotal hernia. Clinical examination showed a giant left-sided inguinoscrotal hernia that descended to the knee in the supine position (Figures 1,2). The penis could not be delivered from the scrotum. Magnetic resonance imaging (MRI) of the scrotum indicated the immigration of the colon, small intestine and omentum into the enlarged scrotum (Figure 3).

In the operating theater, after an initial midline incision and bilateral inguinal incision (Figure 4), the hernia sac was removed, and adhesiolysis, complete mobilization of the abdominal viscera, omentectomy, and right hemicolectomy followed by a jejunocolic anastomosis were performed, offering the extra intra-



Figure 1. Anterior view of the patient.



Figure 2. Left lateral view of the patient.

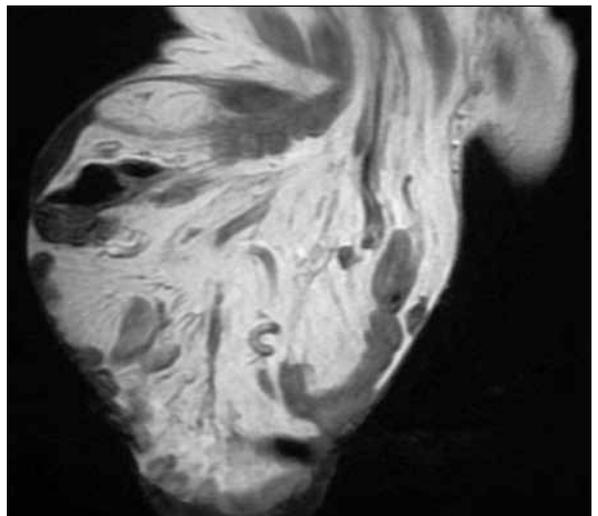


Figure 3. Pre-operative MRI showing colon, small intestine and omentum descended into the enlarged scrotum.



Figure 4. Operative view: bilateral inguinal incision and midline incision.

abdominal space needed for a possible tension-free abdominal wall closure.

Composix mesh was then riveted in the preperitoneal space, buttressing both inguinal regions and extending up to the level of the umbilicus, reinforcing the anterior abdominal wall and permitting a tension-free closure.

## DISCUSSION

Giant inguinoscrotal hernias are defined as those that extend below the midpoint of the inner thigh in the standing position. Giant hernias dramatically impair the patient's quality of life. The affected patient's mobility is very restricted, and they often suffer from voiding difficulties as the scrotum tightens around the penis. The ipsilateral spermatic cord becomes greatly stretched and the testicles are often atrophic or even necrotic. These specific problems have considerable psychological impact, often leading to social isolation. These patients have serious comorbid conditions that have an impact on both initial surgical decision-making and post-operative morbidity and mortality<sup>[1]</sup>.

Giant inguinoscrotal hernia repair implies reintroduction of the herniated bowel into an abdominal cavity accustomed to being empty. Forced reduction of hernial contents into this contracted peritoneal cavity may alter intra-abdominal and intrathoracic pressures (i.e. abdominal compartment syndrome), potentially hastening severe respiratory or cardiac failure and leading to higher morbidity and mortality rates<sup>[2]</sup>. Several techniques have been reported to overcome these problems. Pre-operative pneumoperitoneum has been highly recommended in the past. It is still applied, though to a lesser degree, and its use declined with the introduction of prosthetic materials and a more aggressive approach to the content<sup>[3]</sup>. Creating space for the hernia is another choice. A tension-free repair of the anterior abdominal wall is possible with the use of mesh or musculocutaneous flaps. When soft tissue coverage is also inadequate, regional or distant flaps may be necessary, either

alone or in combination with mesh<sup>[4]</sup>.

The surgical approach varies with different extension midline laparotomies, including lower abdomen inguinal incisions, their complex inguino-abdominal variants to preperitoneal techniques.

Debulking procedure has reportedly facilitated the operation; the method includes resection of the herniating organs, usually the colon, small intestine, or greater omentum, at the price of an increased risk of complications such as anastomotic leak or prosthetic infection<sup>[5]</sup>. Close post-operative monitoring and ventilation are essential in the management of these patients.

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