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Amyand Hernia

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Abstract: ***Different types of hernia have been encountered for the past centuries. one of the rare ones among them is Amyands hernia which was originally described by Claudius Amyand (1685 - 1740) in 1736, a surgeon in St. George hospital London, England, united kingdom. Amyand hernia is seen in approximately1% of all hernias, complication of it, like acute appendicitis, or perforated appendicitis is even more rare, about 0.1%. it s a condition in which the vermiform appendix is trapped within the hernial sac, mostly an intraoperative finding.***

Keywords: amyand hernia, inguinal hernia, acute appendicitis, cecal appendix.

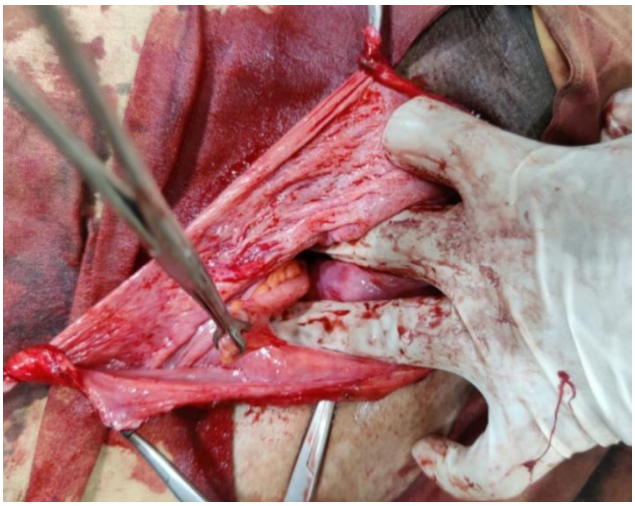
1. Case Report

50yrs old male patient presented to the outpatient surgical clinic with history of bilateral inguinal swelling that progressively grows over 5 yrs, with no associated pain, chronic cough or constipation. He has no comorbidities except 15 years of tobacco chewing.

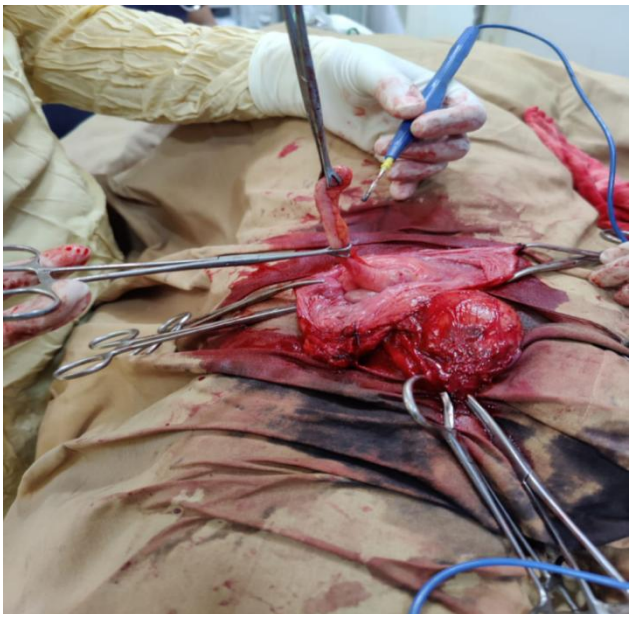
On physical examination, he presented with a bulge in bilateral inguinal region which was irreducible on right side. At Valsalva maneuver, we noticed a protrusion through bilateral inguinal canal, which is more evident while standing on right than the left.

He was diagnosed with bilateral inguinal hernia and was scheduled for an elective surgery. Pre op lab tests were normal.

Surgical management planned, and when we opened the hernial sac on right side, encountered vermiform appendix with signs of inflammation associated with orchitis, thus appendicectomy with orchidectomy along with hernia repair was done. Histopathology suggested chronic appendicitis. The patient got discharged and on follow up no complications.



Intraoperative Finding - Right Inguinal Hernial Sac with Appendixas Content



2. Discussion

Amyand hernia is most frequently encountred in men, and almost exclusively on right side. There is however an exception where the appendix is on the left side situs invertus, intestinalmalrotation, a very loose caecum or a large appendix.

In some cases, it can be accompanied by cecum, bladder, ovary, fallopian tube, omentum or a meckels diverticulum.

Appendicitis in this condition remains the same although the triggering factor may vary from direct trauma to obstruction; both causing reduced flow, ischemia or infection.

Pre op clinical diagnosis is almost impossible but can be done by trans abdominal ultrasound or ct scan. On ct scan, a tubular blind ended structure originating from cecal wall is observed and extends to hernial sac. Our patient had no

clinical or biochemical finding of compromised bowel, so we didn't take any radiological image.

Losanoff and Basson Classification of Amyand Hernia

Classification	Description	Management
Type 1	Normal appendix in inguinal hernia	Hernia reduction with meshplasty
Type 2	Acute appendicitis in an inguinal hernia with no additional sepsis	Appendectomy, primary no prosthesis, hernia repair
Type 3	Acute appendicitis in an inguinal hernia with abdominal wall sepsis	Laparotomy, appendicectomy and primary no prosthetic hernia repair
Type 4	Acute appendicitis in an inguinal hernia with abdominal concomitant pathology	Same as type 3 plus management of concomitant disease.

International literature recommends reducing the hernia content and perform no tension hernia repair. If appendicectomy is performed a clean surgery is combined with a clean contaminated surgery raising the infection rate.

In case where an inflamed or perforated appendix is encountered, no prosthesis should be used because of increased risk of surgical site infection as well as fistula formation in appendicectomy stump. In these cases should ice technique should be considered because of its low recurrence rate.

With new prosthetic materials like biological mesh, current surgical approach in amyand type 2 hernias suggest its use to prevent recurrence. The only disadvantage is its non availability in all hospital settings.

3. Conclusion

Amyand hernia is a rare condition and represents two of the most common diseases a general surgeon has to face. Management involves a laborious surgical technique, and its definitive treatment will depend on surgeon's experience and clinical scenario.

In case of an incarcerated, complicated or strangulated inguinal hernia, the initial approach should be considering imaging studies, ultrasonography or ct scan guided plans and enabling possibility of identifying involved organs. it is important that no delay in definitive treatment is allowed as complications are disastrous.

Conflict of interest: Nil declared

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