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Obstructed Femoral Hernia in Male: A Rare Case Report

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Abstract: ***Obstructed femoral hernias pose a significant challenge to healthcare professionals due to their potential for complications and the need for prompt diagnosis and management. This case report aims to provide a thorough analysis of obstructed femoral hernias, encompassing their clinical presentation, diagnostic modalities, surgical interventions, and postoperative outcomes. By presenting a detailed case and reviewing the existing literature, this report offers valuable insights into the best practices for addressing this critical surgical emergency.***

Keywords: Femoral hernia, obstruction, hernia repair, case study, surgical intervention, complications

1. Introduction

Obstructed femoral hernias represent a relatively uncommon but medically urgent condition that demands immediate attention. Their diagnosis and management require a combination of clinical acumen, radiological expertise, and surgical skill. This journal article presents a compelling case of an obstructed femoral hernia to underscore the complexities and challenges associated with this condition, emphasizing the importance of timely intervention and the critical role of surgery in preventing severe complications.

2. Case

A 67 year old male presented to our OPD with chief complain of abdominal pain for 5 days a/w vomiting for 5 days and constipation for 2 days.

The pain is generalized, moderate to severe in intensity, sudden in onset and progressive, aggravated by movement and relieved by rest. The vomitus is billious, projectile and contains food particles.

The patient was a known case of Bidi smoker for 20 years.

On Examination no any visible swelling, peristalsis noted over abdomen.

Cough impulse were present over bilateral groin region with swelling 2*2 cm^2 below inguinal ligament with smooth overlying surface.

On palpation Abdomen was tense with generalized tenderness, guarding and rigidity.

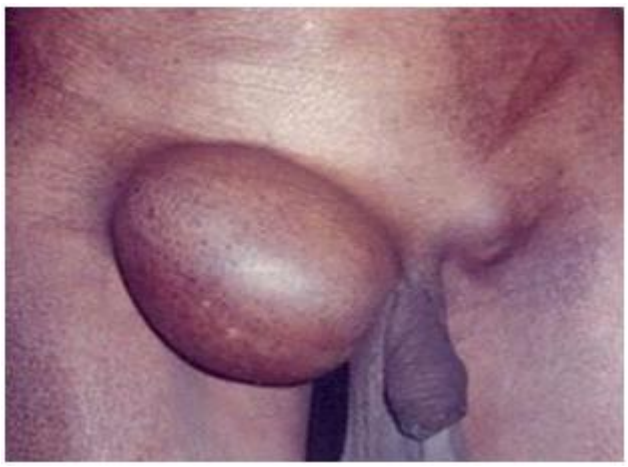
USG (abdomen with pelvis): - shows multiple content loaded dilated bowel loops all over abdomen with to and fro movements. Max. diameter 3.5 cm S/O GI obstruction with right sided obstructed femoral hernia.

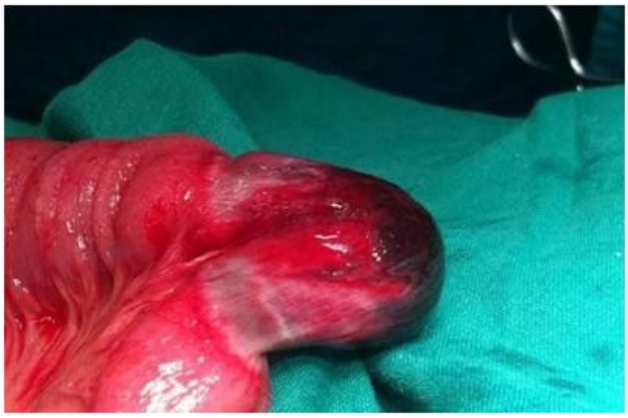
Patient's blood investigations were Normal.

The patient was immediately taken for lower midline exploratory laparotomy with reduction of right ritcher's femoral hernia with primary closure of ileal perforation with Mc vay's repair of right femoral hernia. Drain of size 32 Fr was kept in right pelvic side and abdomen was closed layerwise.

The drain was removed on pod 7 and patient was discharged.

The patient was followed up for next 4 months with no fresh complains.





Clinical picture of the patient showing femoral hernia right side Obstructed part of ileal loop right femoral hernia

3. Discussion

Strangulated femoral hernia is not common event. Rogers [1] reported a review on 170 cases of strangulated femoral hernia and its complications. Two study report strangulated bilateral femoral hernia [2, 3]. Femoral hernia is acquired. This hernia could include: stomach, omentum, colon, small intestines (the partially strangulated small intestine wall called Richter's hernia), the appendix (De Garengeot hernia), urinary bladder, fallopian tube and ectopic testis [4, 5]. The differential diagnosis of femoral hernia includes inguinal lymph nodes, direct and indirect inguinal hernia, hydrocele of the cord or canal of Nuck, the greatest saphenous veinvarices, femoral artery aneurysm, ectopic testis and psoas abscess [4, 5].

Strangulation of femoral hernia is seriously life threatening event. The most important symptom is typically a painful bulge, placed on the medial aspect of the thigh, regularly not easy to palpate in overweight patients. The clinical symptoms are often vague and mainly reliant on the contents of the hernia sac. In the clinical case mentioned above, the patient presented symptoms unique for the gastrointestinal obstruction (constipation and obstipation). Particularly. In the presented case we applied a midline laparotomy incision due to unknown symptoms source. However, throughout this entrée resection of the ischemic intestine segment is not difficult to perform. Moreover, exploration of other cause is possible in this way. This case report strangulated femoral hernia reinforces the value of femoral hernia because of their high risk of incarceration and strangulation. One should be watchful in patients presenting with intestinal symptoms, particularly in case of evocative of bowel obstruction.

Aged fragile patients especially with obstructed femoral hernias may present with unusual symptoms of abdominal pain, nausea, and vomiting. Therefore, careful clinical examination including methodical examination of both inguinal areas, complemented by correct radiological survey, is necessary in the diagnosis of these hernias. Any delay or breakdown to accomplish this diagnosis would result in an appreciably amplified risk of morbidity and mortality for the patient. Hernias must forever be considered as a source if one presents with symptoms of abdominal tenderness or obstruction. The morbidity and mortality raise appreciably in patients undergoing emergent surgery. This highlights the consequence of repairing hernias in an elective situation and suggests that watchful waiting is not a practical approach in patients with femoral hernias, even those who are asymptomatic and stable.

4. Conclusion

Strangulated femoral hernia of the small bowel is rare and the general surgeon should be familiar with femoral hernia as a bowel obstruction source.

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