

Amyand hernia

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Dear Editor,

The presence of a vermiform appendix in an inguinal hernia sac, termed Amyand hernia, was first described by Claudius Amyand in 1735 (1). It constitutes less than 1% of inguinal hernias in adults, and the incidence of having an inflamed appendix in the inguinal hernia (0.1%) is even lower (2). It is usually located on the right side of the lower abdomen. However, few case reports of left-sided Amyand hernia have been reported describing association with situs inversus, intestinal malrotation, and mobile cecum (3).

As the diagnosis of inguinal hernia is usually based on a physical examination, pre-operative imaging is not routinely performed. So, Amyand hernia is often an incidental finding during inguinal hernia surgery (4,5). There are few case reports and little consensus on how surgeons should manage Amyand hernia. There exists an ongoing debate whether an appendectomy is required and also suture versus mesh repair should be preferred. (4-10).

A 55-year-old diabetic male presented with one month of history of bilateral groin pain and swelling. He has been taking antibiotics for 3 weeks for the left groin abscess. He had a history of left inguinal hernia repair with implantation of prosthetic mesh 6 years ago. On examination, his vital signs were stable. He had a reducible right inguinal bulge and a purulent discharge from his left groin, both of which were minimally tender to palpation.

Laboratory studies revealed leukocytosis (white blood cell count, 11.600/ μ L). The elective surgery was planned for both inguinal hernia on the right side and mesh-related infection on the left side. The infected mesh was removed completely through the previous incision and the fascia was reinforced with polypropylene sutures.

The wound was allowed to heal by secondary intention. The right inguinal groin was explored through an oblique incision. An inflamed and edematous vermiform appendix adhered to the hernia sac was seen (Figure 1).



Figure 1. The inflamed vermiform appendix within the inguinal hernia sac

Appendectomy and Bassini repair without prosthetic mesh were performed. Systemic antibiotics were also used. The patient was discharged on the second day and remained uneventful for a further 12 months of follow-up.

There is no consensus on the treatment approaches for Amyand hernia. In this case antibiotics taken for mesh infection may have masked the clinical signs of acute appendicitis. As the patient had diabetes mellitus and previous mesh-related infection appendectomy and hernia repair without prosthetic mesh were performed to avoid potential complications.

Competing interests: The authors declare that they have no competing interest.

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