

Meckel's diverticulitis in Amyand's hernia

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Letter to Editor

The presence of the appendix within an inguinal hernia has been referred to as 'Amyand's hernia' to honour Claudius Amyand surgeon of King George II. Amyand was first to describe the presence of a perforated appendix within the inguinal hernial sac in 1735 [1]. Most cases are diagnosed intra-operatively rather than pre-operatively. Appendicular diverticulitis in an Amyand's hernia was rare [2]. We present a case of an inguinal hernia containing both the Amyand's hernia and a Meckel's diverticulum.

An 86-year-old man presented with a 20-year-old history of a bilateral inguinal mass. The mass in the right groin enlarged and became painful lately. The clinical examination of the abdomen was normal. There were swellings in both groins, the right side being larger and tender, but the skin showed no signs of inflammation. The white blood cell count and the temperature were normal. Ultrasound examination described a hernia

which contains mobile bowel segments inside, on the right side. The operation was performed by an anterior approach through an inguinal incision. A sliding hernia was found with the caecum comprising a hernial wall and the appendix protruding through the hernial sac being edematous and hyperemic (Fig. 1). An appendectomy was done. Further exploration of the bowels revealed a Meckel's diverticulitis which was managed by a wedge resection. We proceeded with the hernia repair and planted a mesh according to the Lichtenstein technique. Histopathologic examination showed a normal appendix vermiformis but revealed a Meckel's diverticulitis. Post-operative recovery was uncomplicated; the patient was discharged 2 days after admission and had no complaints till now.

The presence of the appendix within an inguinal sac is an uncommon condition and is referred to as 'Amyand's hernia'. The incidence of having a normal appendix within the hernial sac is 1 % [1, 3]. Most of the cases of Amyand's hernia occur on the right side, probably as a consequence of the normal anatomical position of the appendix, and also because right-sided hernias are more

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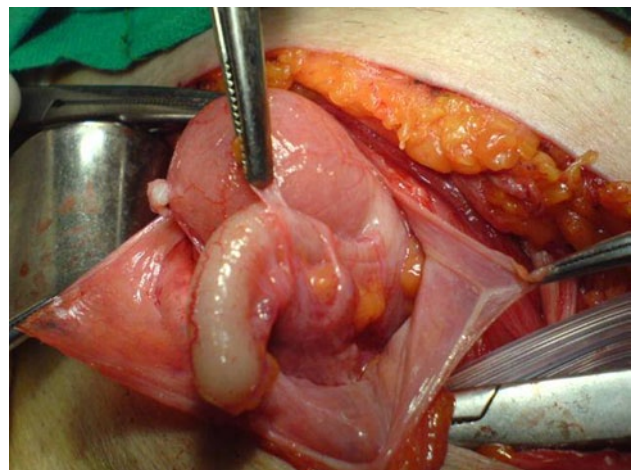


Fig. 1 Appendix seen protruding through the hernia sac

common than left-sided hernias. Our case was also on the right side of the patient. Although rare, Amyand's hernia has also been reported on the left side but this may be associated with situs inversus, intestinal malrotation or a mobile caecum [4, 5].

Meckel's diverticulum is present in 2 % of the population; it is situated on the anti-mesenteric border of the small intestine, commonly 60 cm from the ileocecal valve and is usually 3–5 cm long. Meckel's diverticulum in an umbilical hernia was rare [6]. There is a male preponderance. Any hernia containing Meckel's diverticulum is classified as a Littre hernia. Preoperative diagnosis of Meckel's diverticulum is very difficult [7]. Our case was unique for the presence of inguinal hernia containing both the Amyand's hernia and Meckel's diverticulum. It is very difficult to reach a clinical diagnosis of Amyand's hernia pre-operatively and the diagnosis is made intra-operatively as in the present case. A pre-operative computed tomography scanning could be helpful for diagnosis, but this is not a routine practice. We could diagnose hernia which contains mobile bowel segments inside, on the right side with ultrasound. Absence of any pathognomonic radiological features makes the preoperative diagnosis difficult. Torsion of the testis, epididymo-orchitis and strangulated hernia are considered within the spectrum of differential diagnosis. Fever and leucocytosis are inconsistent findings [8].

In conclusion, Amyand's hernias require individualized attention to decide how to manage both the hernia and the appendix. Clinical scrutiny, a high index of

suspicion and a common sense approach may improve outcomes.

Conflict of interest

Authors declare no conflict of interest related to this article. There is no financial support.

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