

**Giant Incarcerated Inguinoscrotal Hernia with Small Bowel Obstruction in an Elderly Male
Successfully Managed by Emergency Hernioplasty: A Case Report**

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Abstract

Background

Giant inguinoscrotal hernia is a rare form of inguinal hernia extending below the midpoint of the inner thigh in standing position. These hernias are uncommon in modern surgical practice because of improved access to elective surgical care; however, neglected cases may present with serious complications such as incarceration, intestinal obstruction, strangulation, urinary problems, and impaired mobility. Surgical management remains challenging because of distorted anatomy, dense adhesions, and loss of abdominal domain.

Case Presentation

We report a case of a 68-year-old male presenting with abdominal pain, distension, vomiting, constipation, and painful right inguinoscrotal swelling of 15 years duration. Examination revealed a giant irreducible right inguinoscrotal hernia extending below the midpoint of the thigh with features of intestinal obstruction. Imaging studies, including contrast-enhanced computed tomography, demonstrated ileal loops, cecum, appendix, and omentum within the hernia sac causing small bowel obstruction without gangrene or perforation.

The patient was managed with preoperative resuscitation followed by emergency surgery through a right inguinal approach. Intraoperatively, dense adhesions and viable bowel loops were noted. Adhesiolysis and reduction of contents were performed successfully, followed by Lichtenstein tension-free mesh hernioplasty. Postoperative recovery was uneventful, and no recurrence or respiratory complications were observed during follow-up.

Conclusion

This case highlights the importance of early diagnosis, appropriate preoperative optimization, and meticulous surgical management in achieving favorable outcomes in giant incarcerated inguinoscrotal hernias complicated by intestinal obstruction.

Keywords: Giant inguinoscrotal hernia; Small bowel obstruction; Hernioplasty; Incarcerated hernia; Emergency surgery

Introduction

Giant inguinoscrotal hernia is defined as an inguinal hernia extending below the midpoint of the inner thigh in standing position.⁽¹⁾ These hernias are now uncommon because of improved access to elective surgical care. Long-standing untreated hernias may cause incarceration, intestinal obstruction, strangulation, urinary complications, skin ulceration, and impaired mobility.⁽²⁾ Surgical repair is challenging due to adhesions, distorted anatomy, and loss of abdominal domain, which may lead to postoperative respiratory compromise after reduction of contents.⁽³⁾ We report a rare case of giant incarcerated right inguinoscrotal hernia presenting with acute intestinal obstruction managed successfully by emergency surgery.

Case Presentation

A 68-year-old male presented with abdominal pain, distension, vomiting, constipation, and painful right groin swelling for three days. He had a progressively enlarging right inguinoscrotal swelling for 15 years, irreducible for the last six months. There was no history of diabetes, hypertension, tuberculosis, or previous surgery.

On examination, the patient was dehydrated and tachycardic. Abdomen was distended with diffuse tenderness and exaggerated bowel sounds. A giant right inguinoscrotal swelling measuring approximately 28 × 18 cm extended below the midpoint of the thigh. The swelling was irreducible, tender, with absent cough impulse and buried penis within edematous scrotal tissue.

Laboratory investigations revealed hemoglobin 11.4 g/dL, leukocyte count 15,600/mm³, serum sodium 132 mEq/L, and potassium 3.4 mEq/L. X-ray abdomen showed multiple air-fluid levels and dilated bowel loops suggestive of intestinal obstruction. Ultrasonography demonstrated bowel loops and omentum within the hernia sac. Contrast-enhanced CT confirmed giant right inguinoscrotal hernia containing ileal loops, cecum, appendix, and omentum with features of small bowel obstruction but no gangrene or perforation.

A diagnosis of giant incarcerated right inguinoscrotal hernia with intestinal obstruction was made.

Management

The patient was resuscitated with intravenous fluids, nasogastric decompression, antibiotics, electrolyte correction, and catheterization. Emergency surgery was performed through a right inguinal incision.

Intraoperatively, a giant indirect inguinal hernia sac extending into the scrotum with dense adhesions was found. The sac contained distal ileum, cecum, appendix, and omentum. Bowel loops were congested but viable. Adhesiolysis was performed and contents reduced into the abdominal cavity. Posterior wall repair was done using polypropylene mesh by Lichtenstein tension-free hernioplasty. Testicular vascularity was preserved; hence orchidectomy was not required. A suction drain was placed.

Postoperatively, the patient received oxygen support, antibiotics, analgesics, incentive spirometry, and early ambulation. Oral feeds were started after return of bowel sounds. Drain was removed on postoperative day 5, and the patient was discharged on day 8. At 3-month follow-up, there was no recurrence or respiratory complication.

Discussion

Giant inguinoscrotal hernias are rare in modern surgical practice and usually result from neglected long-standing hernias.⁽⁴⁾ Common complications include incarceration, bowel obstruction, strangulation, perforation, urinary retention, and testicular atrophy.⁽⁵⁾

CT imaging is valuable for assessing hernia contents, bowel viability, and operative planning.⁽⁶⁾ Surgical management is difficult because sudden reduction of large hernia contents may increase intra-abdominal and intrathoracic pressure, causing respiratory compromise and abdominal compartment syndrome.⁽⁷⁾

Various techniques including progressive pneumoperitoneum, bowel resection, component separation, and mesh repair have been described.⁽⁸⁾ In the present case, emergency adhesiolysis and Lichtenstein mesh hernioplasty resulted in a favorable outcome without recurrence.

Conclusion

Giant inguinoscrotal hernias are rare but potentially life-threatening conditions. Delayed treatment may result in intestinal obstruction and strangulation. Early diagnosis, proper preoperative optimization, and meticulous

surgical repair are essential for successful outcomes.

Author Contribution

All authors contributed equally.

Conflict of Interest

Nil.

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