Online Case Report

An unusual hernia complication: a late presentation

NEERAJ PUROHIT, ROSHAN DRABU, JOHN LANKESTER

Surgical Department, Luton and Dunstable Hospital, Luton, UK

A 67-year-old man presented with a 10-year history of intermittent right iliac fossa pain. His only significant past medical history was an inguinal hernia repair 10 years ago. After investigations, the patient underwent a laparotomy. He had a localised caecal perforation secondary to a misplaced prolene suture. A right hemicolectomy was performed.

Keywords: Hernia – Perforation – Complications

Mr JM, a 67-year-old part-time construction worker, was admitted to the Luton and Dunstable Hospital, Luton, UK on 15 November 2005. He had a 3-day history of right-sided abdominal pain which was dull and constant in nature. The pain on the day of admission had become worse and was aggravated by movement. Associated with the pain, he described a 3-day history of loose stools, with no blood or mucous, and had vomited twice on the day of admission. He complained of no urinary symptoms. Of note, Mr JM had similar episodes of right-sided abdominal pain over the past 10 years, but all had resolved after a few hours when treated with Kolanticon Gel, an antimuscarinic drug.

Mr JM underwent a right inguinal hernia repair 10 years previously, but had no other co-morbidities. He was not taking any regular medication, and had no known drug allergies. Alcohol intake was around 12 pints of Guinness a week, and he was a non-smoker.

On initial examination, he was in obvious discomfort. He was afebrile and haemodynamically normal. Respiratory and cardiovascular systems were unremarkable. On abdominal examination, he had a non-distended abdomen with a visible scar from his previous right inguinal hernia surgery. On palpation, he had marked tenderness, and guarding predominantly in the right iliac fossa. There

were no palpable masses and rectal examination was unremarkable. Bloods, urine analysis, plain film abdominal and erect chest radiographs were all within normal limits.

At this stage, the working diagnosis was that of acute or chronic appendicitis. On review on the post-take ward round, the pain was still present and CT abdomen was requested. On 17 November 2005, the CT reported evidence of inflammatory change in the right iliac fossa, with probably localised perforation. No frank obstruction

Figure 1 A perforation through the caecum and inflamed ileum.

Correspondence to: Neeraj Purohit, Surgical Department, Luton and Dunstable Hospital, Lewsy Road, Luton LU4 0DZ, UK

E: neerajpurohit@hotmail.com

was seen. In view of the clinical findings and CT scan result, a decision was made to proceed to laparotomy which was done on 18 November 2005. The findings were that of an inflammatory mass involving the caecum, appendix, and terminal ileum, and a small perforation in the proximal part of the ascending colon (Fig. 1). There was a prolene suture from the anterior abdominal wall passing through the caecum. A right hemicolectomy was performed, with a stapled anastomosis. The peritoneal cavity was lavaged with normal saline and the abdomen was closed en mass.

The patient was stable in the postoperative period and had an uneventful recovery. He was discharged from clinic as he had no further symptoms.

Discussion

Groin hernias are among the most common surgical diseases. Tension-free hernioplasty with mesh-repair is one of the commonest and safest techniques for inguinal hernia repair.^{2,4} The diagnosis was unclear from the time of presentation, and was only apparent at laparotomy. The duration of the patient's symptoms of intermittent

right-sided abdominal pain began soon after his right inguinal hernia repair and was due to a complication from this operation.

During repair of an inguinal hernia, care should be taken not to place sutures too deeply through the abdominal wall due to the underlying structures. Polypropylene mesh-related complications following hernia repairs have been well documented.¹ There are case reports of perforated viscus from inguinal hernia repairs;³ however, complications arising from a solitary misplaced suture are rare.

References

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