Case Report

Unusual presentation of acute pancreatitis mimicking strangulated inguinal hernia in a patient with bladder exstrophy: a rare case report

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ABSTRACT

Acute pancreatitis (AP) is a common surgical emergency. Apart from the typical clinical presentation, unusual presentations are also reported in literature. Here we present a case of acute pancreatitis presenting as a strangulated inguinal hernia. A 45-year-old male with a neglected bladder exstrophy and reducible left inguinal hernia since childhood presented with pain over the left inguinal swelling for three days duration. Patient was initially managed conservatively since there were no signs of complication. After initial conservative management, the patient developed features of strangulation and was taken up for inguinocrotal exploration. Intra-operatively, direct inguinal hernial sac was identified without any bowel obstruction. Further explorative laparotomy revealed an inflamed, bulky pancreas. The peri-pancreatic fluid aspirated intra-operatively had an amylase value of >4000 IU. Postoperative period was uneventful and patient was discharged after 8 days. In this case an already reducible hernia became irreducible due to pancreatic fluid collection and inflammation of contents. Lack of abdominal symptoms or signs can lead to misdiagnosis and unnecessary surgery. We report an unusual presentation of acute pancreatitis mimicking a strangulated inguinal hernia in a patient with bladder exstrophy.

Keywords: Bladder exstrophy, Pancreatitis, Surgical emergency, Strangulated hernia

INTRODUCTION

AP is an acute inflammatory process of the pancreas with/without involvement of regional tissues or remote organs.1 The clinical presentation of pancreatitis is highly variable. It commonly presents with acute epigastric pain radiating to the back, nausea and vomiting. The diagnosis is arrived at from history, enzyme levels (amylase or lipase) and imaging studies.2 There is very scarce literature on acute pancreatitis presenting as an inguinocrotal swelling.2 The wide variety of presentation can lead to delay in diagnosis and management of AP. Here we present a case of AP presenting as a strangulated inguinal hernia.

CASE REPORT

A 45-year-old gentleman with a neglected bladder exstrophy and reducible left inguinal hernia since childhood, presented to the emergency medical services, with complaints of pain in the left inguinal swelling for 3 days. The patient did not complain of abdominal pain, nausea or vomiting. He did not have altered bowel habits. He gave history of frequent alcohol intake for 20 years of age. He does not give history of any similar episode in the past. On examination, the patient had bladder exstrophy and had an irreducible left inguinal hernia but did not show any feature of obstruction/strangulation. The patient was managed conservatively for 2 days as a
case of irreducible inguinal hernia, during which period
he was stable and did not show worsening of symptoms.

Further explorative laparotomy revealed an inflamed,
bulky but viable pancreas with saponification in the
omental fat and small bowel mesentery. Thorough
peritoneal lavage and drain was placed and left inguinal
herniorrhaphy was done.

The fluid aspirated intra-operatively had an amylase
value of >4000 IU/L. Serum amylase was found to be
1200 IU/L. Postoperative period was uneventful and
patient’s condition improved and drain was removed
on the post-operative day 4 and was discharged after 8 days.

DISCUSSION

AP is a potentially fatal disease with a mortality rate of
5%. Given the dangers of misdiagnosing pancreatitis,
awareness of unusual presentations is of paramount
importance. Alcohol abuse, gallstones, hypertriglyceridemia, hypercalcemia, medications,
ERCP, and trauma account for most cases of AP.
However approximately 20% remain idiopathic.1 AP has
a myriad of presentations where very few cases reported
in literature underwent surgical exploration.2 Almost all
reports are associated with severe pancreatitis. Even
though most of them had acute fluid collection in the
inguinoscrotal region, AP presenting as a mass in the
inguinal region is extremely rare.3 Erythema may occur
over the swelling due to localised fat necrosis secondary
to enzyme-rich pancreatic exudates or irritation from
necrotic pancreatic debris. Acute idiopathic
inguinoscrotal edema is a rare complication of AP and
could be mistaken for a more common pathology.4

The fluid in peri-pancreatic collections can track retro-
peritoneally into the inguinoscrotal region, traversing
the deep and superficial inguinal ring. In this case an already
reducible hernia became irreducible due to pancreatic
fluid collection and inflammation of contents.5 In the
pathogenesis of AP, secretions may extend to unusual
anatomical locations, presenting with clinical features
which may be misinterpreted, unless there is a high index
of clinical suspicion.6 As pancreatitis progresses, fluid
arising from the pancreas can leak into the retroperitoneal
and peritoneal spaces.7 In such a scenario it can mimic
obstructed hernia, testicular torsion, acute epididymo-
orchitis, hydrocele or testicular tumour.8 The
management of such should be the least invasive possible
method but also the most complete possible method to
avoid unnecessary interventions. This case highlights the
challenging nature of diagnosing pancreatitis and the
importance of retaining a high index of clinical suspicion
for AP in patients with abdominal pain or systemic illness
of obscure aetiology.

CONCLUSION

AP manifesting as inguinoscrotal swelling is a rare
presentation, causing a diagnostic dilemma. The presence
of a congenital anomaly in the form of bladder extrophy
where inguinal hernia is common is causing additional
A missed diagnosis may lead to unnecessary surgery and improper or delayed treatment.

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