Case Report

Vasitis Vs Incarcerated Inguinal Hernia: A Differential Diagnosis Challenge

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Abstract

Inflammatory vasitis is a rare entity and a challenging diagnosis to differentiate from inguinal hernia. We are reporting the case of a 54-year-old man with inguinal pain who underwent emergency surgery for suspicion of an incarcerated inguinal hernia diagnosed by ultrasound. No incarcerated hernia was found at surgery. Instead, inflammation was present around the deferens. Since a small indirect, non-incarcerated hernia and a weakness of the inguinal floor were found, repair with a mesh was done. A physical examination the following morning revealed exactly the same induration associated with inguinal pain. A CT scan was obtained on post-operative day one, and the clinical evolution raised suspicion of a vasitis. The patient was then treated accordingly with antibiotics. Ultrasound did not clearly differentiate vasitis from incarcerated hernia. In case of a questionable incarcerated inguinal hernia, a CT scan should be performed and may lead to an avoidance of surgery.

Keywords: Vasitis; incarcerated inguinal hernia; general surgery; inguinal imaging; differential diagnosis

Introduction

Vasitis is a condition separated by Chan and Schlegel [1] into two clinical entities. First, vasitis nodosa is a common asymptomatic urologic disease localized at the vas deferens. This is often associated with a history of vasectomy (50-60%) [2]. Second, the medical literature rarely reports an isolated infection of the vas deferens (inflammatory vasitis) described as an inguinoscrotal pain with the emergence of an irreducible mass that can be easily confused with an incarcerated inguinal hernia. Acute vasitis is mostly caused by backward infections from the prostatic urethra, prostate or seminal vesicles. The common pathogens are Escherichia coli and Haemophilus influenzae [3]. The usual appropriate treatment is antibiotics, as in epididymitis cases [3-5].

Case Report

A 54-year-old man presented at the emergency department with a complaint of left inguino-scrotal pain including the appearance of a non-reducible mass in the groin. He had a vasectomy 5 years ago, and suffered from type 2 diabetes mellitus. The patient did not report symptoms of urinary tract infection but had a temperature of 38.2 °C. The patient had been with a stable sexual partner for 17 years. He had no history of sexually transmitted infections but was known for previous urinary tract infections. Physical examination revealed a redness of the scrotum and an irreducible mass was palpated in the left inguinal area and in the posterior tes-
tes area. Laboratory results revealed a leukocytosis (14.3 x10⁹/L) with 82% neutrophils; the C-reactive protein was elevated at 130.2 mg/L. Urine analysis revealed 11-20 leucocytes count and positive nitrites.

A testicular ultrasound revealed a distension of the inguinal canal with a 4-cm hyperechoic mass extending to the scrotum. The presumed hernia seemed to contain omentum but no bowel loops (Figure 1A). The color doppler imaging showed hypervascularity suggesting venous congestion (Figure 1 B).

Following the diagnosis of an incarcerated inguinal hernia, the patient was brought to the operating room to undergo an inguinal hernia surgery repair. During the operation, a small indirect hernia was noticed with no content and the presence of inflammatory tissue limited around the vas deferens. A mesh was positioned to strengthen the weakness of the inguinal area. The day after surgery, the surgeon noticed the persistence of an inguinal hernia. Urine culture was positive for an E. coli urinary infection with >10⁸ bacteria/L. A new ultrasound was prescribed and the radiologist noticed the persistence of an inguinal hernia consistent with a hernia. This diagnosis did not correspond to what was observed during surgery, so a CT scan was done to characterize the condition with more precision. The scan revealed the presence of iatrogenic air densities in the region of the inguinal canal, with inflamed fat and a persistence of fat hernia in the left hemiscrotum. Calcification of the vas deferens was also identified (Figures 2).

Discussion
Vasitis was reported by Wesson [8] in 1926 and Wolbarst [9] in 1933, being clinically confounded with hernia (Table 1).

| Authors and year of publication | Number of cases of vasitis | Patients | Radiologic Investigation | First Diagnosis | treatment |
|--------------------------------|---------------------------|----------|--------------------------|-----------------|-----------|
| Maitra AK 1970[10]             | 1                         | 67 yo    | None                     | Incarcerated Inguinal hernia | Surgery: Drainage of an abcess adjacent to the vas deferens. Excision of the cord and testis |
| Bissada BK 1976[11]            | 1                         | 46 yo    | None                     | Incarcerated Inguinal hernia | Surgery: excision of the vas |
| Ryan SP1988[12]                | 1                         | 25 yo    | None                     | Incarcerated Inguinal hernia | Surgery: drainage of an abcess adjacent to the vas deferens |
| Eddy K 2011[3]                 | 3                         | 40, 32 and 61 yo, Ultrasound and CT | Vasitis | Antibiotics |
| You SH[7] 2013                 | 1                         | 69 yo    | CT                       | Strangulated Inguinal hernia | Debridement and antibiotics |
| Patel K 2014[13]               | 1                         | 55 yo    | Ultrasound and MRI       | Vasitis          | Antibiotics |
| Romero Marcos JM 2016[14]      | 1                         | 42 yo    | Ultrasound and CT        | Amyand’s hernia  | Laparoscopic exploration. Incisional biopsy of the inflamed vas deferens |
| Kerkeni W 2016 15              | 1                         | 31 yo    | Ultrasound and CT        | Vasitis          | Antibiotics |

Table 1: Case reports of vasitis confused with incarcerated inguinal hernia

In these case reports, it is recommended to use a CT scan [3.5] to differentiate these two entities. In almost all case report of inflammatory vasitis, the CT scan allowed a formal diagnosis of this clinical entity [3-5]. A unique case presenting inconclusive scanner imaging was described by S. Hye You et al [7]. As a case of “Emphysematous Vasitis” in a patient with a history of vasectomy, type 2 diabetes and a urinary infection with E. coli. Another case was confused with Amyand’s hernia. According to the literature review, most of the vasitis cases were due to a urinary tract infection by a microbiological pathogen [4] in patients with previous vasectomy. Therefore, painful inguinal mass with urinary tract infection and clinical history of vasectomy could guide clinicians to the diagnosis of vasitis. Urinary tract infection is not related to incarcerated omentum, as suspected in this case with the ultrasound. Infectious signs and urinary tract infection should have led to a CT scan, avoiding unnecessary operation. Surgeons and radiologists should be aware of this rare condition.

**Conclusion**

In conclusion, in case of questionable incarcerated inguinal hernia, a CT scan should be performed. A high level of suspicion by the radiologist and the surgeon is desirable to guide the diagnosis. The symptoms and the patient’s history of vasectomy associated with the urinary tract infection could have led the clinician to a faster diagnosis of inflammatory vasitis and therefore spared him the unnecessary surgery. These symptoms complex should be pointing to differential diagnosis of vasitis. Antibiotherapy is the treatment for vasitis, not surgery [3-5].

**Informed consent statement:** The patient gave informed, written consent for publication on this case report.

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**Conflict of interest:** The authors declare that they have no conflict of interest.

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