INTRODUCTION

The presence of a vermiform appendix inside a hernial sac is not a common condition. In the literature, the reported incidence is around 1% of all hernias. It is even rarer to find an acute appendicitis inside the inguinal hernia.

When the cecal appendix, inflamed or not, is found in the inguinal sac, it is called an Amyand hernia. This kind of hernia is more frequent in men and pre-operative diagnosis is not easy. It must be suspected in patients with a tense inguinal hernia with no signs of intestinal obstruction. The appendectomy will always be carried out at the same time as the repair of the hernia.

The aim of the present study is to present a case of acute appendicitis within a right inguinoscrotal hernia and to review the literature.

CASE REPORT

A 35-year-old male farmworker arrived at the General Surgery Service of the Hospital Universitário Oswaldo Cruz, Recife, Pernambuco, Brazil. He reported the appearance of a mass in the right inguinoscrotal region for around one month without pain. Two days previously he had begun to experience epigastric pain with nausea and vomiting. He visited his local health service and received treatment for gastritis. As the pain continued and was located in the right iliac fossa, he was admitted to hospital. A physical examination revealed a heart rate of 100 bpm, a respiratory rate of 21 ipm, PA=130x80 mmHg and an inguinoscrotal hernia on the right side with slight irritation of the peritoneum. He was referred for surgery and the procedure revealed an inflamed appendix with purulent secretion at its apex within the hernial sac. As surgical access was by transverse incision of the inguinal hernia, it was decided to perform the appendectomy and the Bassini repair of the hernia simultaneously (Figure 1). Antibiotic prophylaxis with metronidazole and ceftriaxone was carried out for 24 hours. After two days, the patient was discharged from hospital with no complications. The result of the biopsy confirmed the appendicitis.

DISCUSSION

Some authors believe that a cecal appendix in an inguinal hernia was first described by De Garengeot in 1810.

ACKNOWLEDGEMENTS

The authors thank Priscilla Vieira Ely Hattori, technique laboratory of the Federal University of Grande Dourados (Dourados, Mato Grosso do Sul) for logistical support offered to the writing of this Letter to the Editor.
1. Carey LC. Acute appendicitis occurring in hernias: a report of 10 cases. Surgery 1967; 61:236-8.
2. Doyle GS, McCowan C. Amyand hernia: a case of an unusual inguinal hernial. Am J Emerg Med 2008; 26(5):637. e5-6.
3. Franko J, Sulkowski R. A rare variation of Amyand’s Hernia. Am J Gastroenterol 2002; 97(10):2684-5.
4. Gillion JF, Bomet G, Hamrouni A, Julles MC, Convard JP. Amyand and de Garengeot’ hernias. Hernia 2007; 11(3):289-90
5. Hiatt JR, Hiatt N. Amyand’s hernia. N Engl J Med 1988; 318(21):1402.
6. Hotiana MM, Kundu S, Ahmad I. Complicated inguinal hernia of Amyand. South Med J 2007; 100(4):411.
7. Lippolis PV, Barletti M, Filidei F, Seccia M. The Amyand hernia. Case report and review of the literature. Ann Ital Cir 2007; 79(2):153-7.
8. Logan MTBS, Nottingham JM. Amyand’s hernia: a case report of an incarcerated and perforated appendix within an inguinal hernia and review of the literature. Am Surg 2001; 67(7):628-9.
9. Losanoff JE, Basson MD. Amyand hernia: what lies beneath—a proposed classification scheme to determine management. Am Surg 2007; 73(12):1288-90.
10. Prieo P, Lobo E, Moreno I, Sánchez-Picot S, Gil Olarte MA, Alonso N, Fresnedo V. Acute appendicitis in an incarcerated crural hernia: analysis of our experience. Rev Esp Enferm Dig (Madrid) 2005; 97(10):707-715.
11. Rodríguez Montes JA. Historias de la cirugía. AstraZeneca 2003; 87-102.
12. Ryan WJ. Hernia of the vermiform appendix. Ann Surg 1937; 106:135-9.
13. Torres Hernández D, Rosello Fina JR, del Campo Abad R, Canals Rabasa PP, Enriquez Weinmann ES. Hernia de Amyand: presentación de un caso y revisión de la literatura. Arch Cir Gen Dig 2003; 22 Sep. Available at: www.cirugest.com.
14. Weber RV, Hunt ZC, Kral JC. Amyand’s hernia. Etiologic and therapeutic implications of two complications. Surg Rounds 1999; 22:552-6.

INTRODUCTION

The actual incidence of foreign bodies retained in the abdominal cavity is not well known, as such cases are under-reported. They occur even with highly experienced surgeons and may cause serious consequences. Related risk factors require the adoption of systematic preventive measures.

This paper aims to report a case involving a surgical sponge abandoned after cholecystectomy that migrated into the duodenum and was successfully removed by upper digestive endoscopy.

CASE REPORT

A 26-year-old female patient underwent videolaparoscopic cholecystectomy converting to open surgery due to choledocholithiasis. Cholecystolithotomy plus Kehr drainage was then performed. The patient had a good recovery, but after nine months she sought medical care presenting antropyloric obstruction syndrome (epigastric pain, recurrent postprandial vomiting, and weight loss).

Upper digestive endoscopy revealed the presence of a foreign body, probably a surgical sponge, in the gastric cavity, in the transpyloric region, blocking the passage of the equipment (Figure 1A). Abdominal CT scan (Figure 1B) revealed a well-defined mass located between the liver and the stomach, with mixed density, air bubbles in its inside, and spiral radiopaque stripes representing the sponge markers.

With a diagnostic hypothesis of pyloric obstruction caused by a foreign body, a new upper digestive endoscopy was performed in an attempt to remove the sponge, which was successfully done by snare polypectomy (Figure 2A). After the removal of the foreign body (Figure 2B) superficial esophageal lacerations were observed with self-limited bleeding and a blocked deep ulcer occupying almost all the anterior wall of the duodenal bulb, with no signs of cavity perforation.