A 72-year-old, female patient presented with abdominal pain in the right flank for two days. Physical examination revealed pain at palpation and painful decompression, particularly in the right lower quadrant of the abdomen. The patient was afebrile and did not report diarrhea or vomiting episodes. Blood count revealed leukocytosis (11,900 cel/mm$^3$), and the patient was submitted to abdominal computed tomography (Figure 1).

Figure 1. A: Abdominal computed tomography, coronal reconstruction. B: Axial section at the level of the pelvis.
Appendix within the hernial sac and entering the inguinal canal, representing the vermiform of a blind-ending tubular structure arising from the cecum. Constructions are particularly useful for the visualization of inguinal hernias, and sagittal and coronal re-
nates and patients above the age of 70 distribution as regards age range, affecting principally neo-
mores prevalent in male individuals and presents bimodal

**Diagnosis:** Amyand's hernia with perforated appendici
tis. The presence of appendicitis with inflammatory signs located in the hernial sac (type II her-
nia), generally are treated by means of hernia repair and appendectomy, possibly by inguinal approach. Appendicitis with signs of perforation, as well as the presence of peritonitis and intra-abdominal extension of the inflammatory process (type III hernia) is approached by means of laparotomy. The association with other abdominal conditions, such as tumor or abdominal masses (type IV hernia), requires an appropriate individualized approach. Thus, the recognition of such situations is essential for an appropriate management of cases.

Finally, Amyand's hernias are rarely found and com-
monly underdiagnosed. Computed tomography and recon-
structions represent a highly useful tool for a correct diag-
osis. The radiologist must recognize these situations, iden-
tifying the factors which change the classification and ap-
proach to these hernias.

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