Introduction

The description of an abdominal hernia can take into account two factors: either the location or the content of the hernia. If the hernia is described according to the location, we can call inguinal, femoral, Spigel, obturator, lumbar, sciatic, diaphragmatic or incisional hernias. Three types of hernia have been described according to their content: Littré's hernia (contains a Meckel diverticulum), Richter's hernia (contains an antimesenteric part of the small intestine) or Amyand's hernia [1]. The latter contains an acute appendicitis and was named in memory of Claudius Amyand, author of the first appendectomy performed in the history of medicine in 1735, at St George’s Hospital in London, for acute appendicitis within an inguinal hernia [2].

Case report

This is a 2-month-old patient with a history of reducible right inguino-scrotal hernia, admitted for management of right inguino-scrotal swelling of irreducible inflammatory appearance (Figure 1) for 6 hours prior to admission, associated with vomiting and transit disorder, with a fever of 38.7. On general examination, the infant was hemodynamically and respiratorily stable, and on objective local examination there was right inguino-scrotal swelling of irreducible inflammatory appearance with redness and a testis that was not palpable on the right due to local edema (Figure 1). No abnormalities were noted on the biologic (WBC: 10,3 ×10^9/L, CRP:5mg/L) and radiologic work-up. The patient was taken to the operating room for management of a strangulated inguinal hernia.

Intraoperatively the body of the appendix were stuck to the hernia sac. The appendix was perforated with an inflamed distal part (Figure 2). The base of the appendix and the cecum were normal and the testis was viable. An appendectomy and closure of the hernial sac was performed. The patient received 3 days of cefoxitin 80 mg/kg/day. The postoperative sequelae were uneventful. No complications were noted.

Discussion

The positional variations of the cecum and appendix allow...
the appendix to reach almost all abdominal hernial orifices. Thus, the discovery of appendicitis inside a hernia obturator [3,4], Spigel’s [5,6], umbilical [7], diaphragmatic, intrathoracic [8–10], incisional [11] or in a laparoscopic trocar port [12] has been described. Right inguinal and femoral hernias are the most common site for the development of an Amyand’s hernia, but this entity has also been described on the left side [13]. Among incarcerated hernias containing viscera, the presence of the appendix is estimated to be 1% [14,15]. The development of acute appendicitis within a hernia sac (Amyand’s hernia) is estimated to be 0.13% of all appendicitis [14].

The clinical presentation of an Amyand’s hernia is that of a strangulated hernia, that is, the development of a non-reducible inguinal arch, but without digestive occlusion. An inflammatory syndrome may develop depending on the course of acute appendicitis [16].

The diagnosis of Amyand’s hernia is difficult to make and is often discovered intraoperatively if surgery is decided quickly. Delay or failure to treat can be fatal. Indeed, Carrey described a mortality rate of three out of ten patients with Amyand’s hernia in the 1960s [13]. Today, diagnostic capabilities have improved significantly and computed axial tomography (CT) scans are available for preoperative diagnosis [17,18] (Figure 3).

Surgically, when a non-inflamed appendix is discovered during elective hernia repair, it is advisable to perform an inguinal appendectomy and hernia repair without the use of prosthetic material because of the risk of bacterial contamination [1,16,19]. In the case of Amyand’s hernia with acute appendicitis, the surgeon will also perform an inguinal or abdominal appendectomy if the periaappendicular inflammation is extensive. The cure of the hernia will of course be done without prosthetic material.

A non-reducible incarcerated hernia is a surgical emergency and must be operated on as soon as possible. In case of unavoidable delay, an attempt to reduce the hernial sac must be a considered gesture. Indeed, it is possible to reduce the hernia en bloc with its hernia ring allowing a continuation of the intestinal suffering intra-abdominal with risk of perforation and peritonitis. An attempt of gesture must be carried out by an experienced surgeon, with the possibility of a close clinical supervision and if necessary an emergency intervention.

**Conclusion**

Amyand’s hernia is a rare but important disease to know. Its clinical picture is similar to that of a strangulated hernia. Amyand’s hernia generally has a good prognosis, although serious complications have been described. So a surgeons must be prepared to avoid the effect of surprise and ensure adequate care without further complications.

**Ethical considerations**

The patient’s parents confirmed the patient’s approval.

**References**

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