Case Report

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Rare Case of Appendicitis in Hernial Sac-Amynad's Hernia Type 2 Case Report

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Abstract

Amynad's hernia is the term used for hernia with content as Appendix and part of caecum. This can be presented as incarcerated hernia and rarely with acute appendicitis. Here we are presenting a case acute abdomen with appendicitis in the inguinal hernia. This case is reported in a 68 yr old man with long standing hernia presented as acute pain and vomiting. This case report is reported due to its rarity.

Keywords: Amynad's hernia: appendicitis in hernia; Incarcerated hernia.

INTRODUCTION

A rare condition where the content of the hernia is appendix and part of caecum is named as Amynad's hernia. The incidence is 0.07 to 0.13%. Acute appendicitis in Amynad's hernia is very rare and the presentation will be like obstructed hernia. The name was given in recongnition of Claudius Amynad who first did and appendcectomy on 11 r old boy named Hanvil Anderson in 6th December 1735.[1,2]

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The condition is suspected (*i*) when there is acute pain over the hernia without features of intestinal obstruction and with eflux vomiting, (*ii*) right sided hernia with local tenderness and fever The investigations like USG and CECT can identify the appendix and inflammation helping in more acurate preoperative diagnois.[3,4]

Fernando and Leelaratna classified it as (*a*) noninflamed appendix, (*b*) inflamed appendix and (*c*) perforated appendix.

We suggest a protocol based on the literature review and it is given below.[3]

Type	Finding	Treatment Protocol
Type 1	Noninflamed appendix	Primary mesh repair
Type 2	Inflamed within sac	Primary mesh repair with appendicectomy
Type 3	Peritoneal contamination	Repair by anatomical method following mangment of appendix and peritonitis

Many other classification and categorization are there but they are of no clinical significance and

important in management.

CASE REPORT

68 yrs old male patient who was under investigation for Lymphoma/Leukemia came to emergency with severe pain over the right inguinal hernia with single attack of vomiting. There was no abdominal distension or constipation. He had hernia for 4 yrs without any symptoms. The clinical examination showed a direct type of hernia with severe tenderness at the lower part of the hernia. There was no features of inflammation of skin and was not tense. Mild tenderness was there at the right iliac fossa. No other positive findings were there.

Investigations showed Polymorphonuclear leucocytos is with Total count of 38000/cubic mm and polymorphs 78%. ESR was 40mm/1hr. CRP was 130. CECT showed inflamed appendix with size 10mm in the apex of the hernia with fluid having consistency of blood.

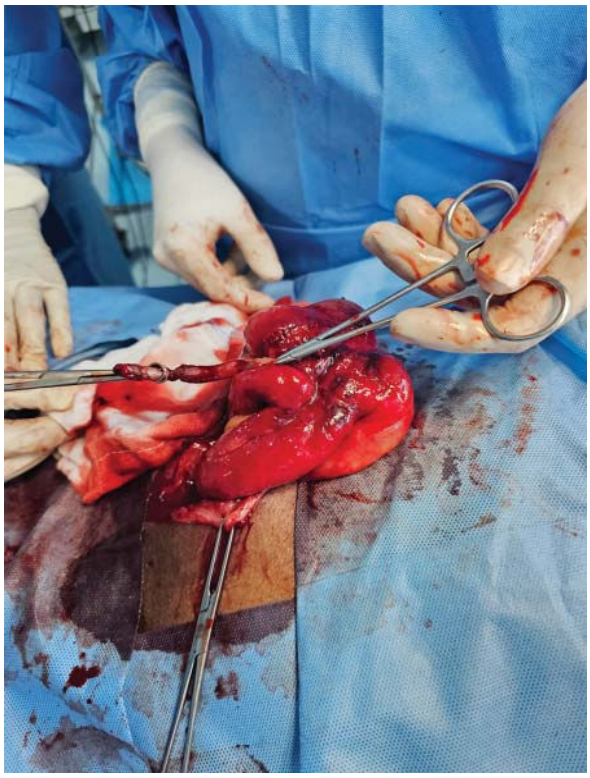


Fig. 1: CT Showing the inflamed appendix with part of Caecum.

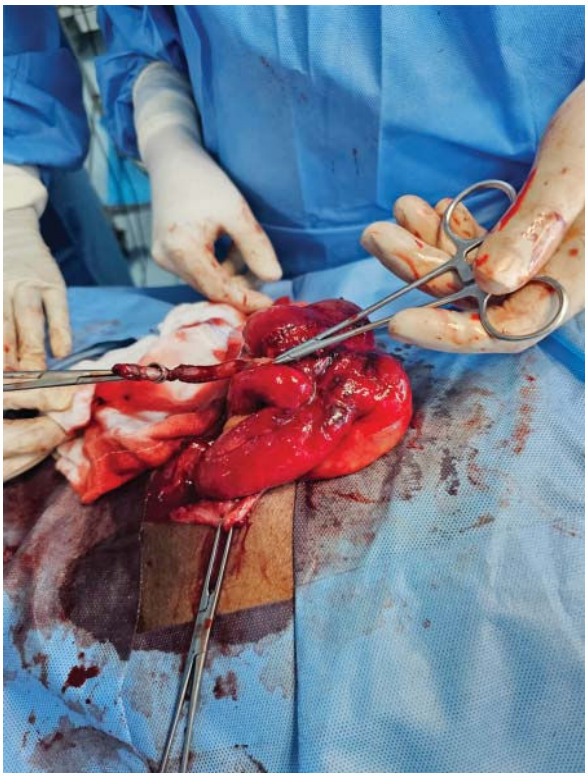


Fig. 2: Fluid collection and Mass formation in the sac

He was subjected for exploration under General anesthesia. By inguinoscrotal approach there was a large hernia with sac containing haemorrhagic fluid 40ml.

There was mass of omentum adherent to the appendicular area with inflamed necrosed appendix with mass formation and haematoma like appearance. The appendicectomy done and the primary repair of the hernia done with mesh.

Post-operative period was uneventful and discharged on 4th day.



Fig. 3: Pre-operative picture of inflamed appendix and caecum

DISCUSSION

The pathophysiology of appendicular inflammation in Amynad's hernia is compression and trauma which produces external inflammation. The USG will show blind ending tube with features of inflammation with part of cecum in the sac.[2]

The Management Protocol Summarises

If appendix is accidental finding and no inflammation classical hernia repair with mesh may be done excising the sac. In case of appendicitis the sac can be explored and remove the appendix and go for the primary repair of the hernia with mesh. If the appendicitis is with perforation peritonitis classical anatomical repair may be done and further evaluation and procedures required.

In our case there was a mass formation with omental tip and the appendix was inflamed forming a mass. We removed appendix and inflamed omentum. Primary repair of the hernia done with prolenemesh. Peritoneal drain and wound drains were placed and they were removed after 72 hrs.

CONCLUSION

We are presenting rare a case report of Amynad's hernia with inflamed appendix as the content. The appendix in hernia usually present as incarcerated and clinical presentation may be of obstructed hernia. Preoperative conformation by USG and CECT will help management based on protocol.

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