

Case Report

Left Claudius Amyand Hernia in an Infant: A Case Report

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Abstract

Claudius Amyand's hernia is a rare condition in children. Strangulated inguinoscrotal hernias are common surgical emergencies. Claudius Amyand's hernia is defined by the presence of an inflamed or non-inflamed vermiform appendix within an inguinal hernia sac.

We report a case of Claudius Amyand's hernia in a 3-month-old infant with an untreated simple inguinoscrotal hernia, presenting with signs of incarceration. Incidentally, the appendix was found within the inguinal canal. Management consisted of appendiceal preservation and inguinal hernia repair. The postoperative course was uneventful for our patient.

Left-sided Amyand's hernia is a rare condition whose diagnosis is typically made preoperatively. The procedure involves ligating the hernia sac with appendectomy if an inflamed vermiform appendix is present.

Keywords: Claudius Amyand's hernia; Inguinal hernia; Infant; Large scrotum; Appendix

Introduction

Strangulated inguinoscrotal hernias are common surgical emergencies. Claudius Amyand's hernia is defined by the presence of an inflamed or non-inflamed vermiform appendix within an inguinal hernia sac. This anomaly was first described by Claudius Amyand in a successful appendectomy performed on an 11-year-old boy in 1735 [1]. Preoperative diagnosis is rarely made, and it is typically discovered incidentally during surgery [2,3].

Case Presentation

This was a 3-month-old infant presenting with an untreated inguinoscrotal swelling, admitted for a strangulated left inguinoscrotal hernia. Symptoms began one day prior to admission, characterized by a painful inguinoscrotal swelling with associated inflammatory signs, without vomiting or cessation of bowel movements or gas. On physical examination, the patient was conscious, hemodynamically and respiratorily stable, with preserved general condition and afebrile. He exhibited an irreducible and painful left inguinoscrotal swelling with inflammatory signs, along with a soft abdomen. The right testicle was in place (Figure 1). Radiographic assessment, represented by a standing thoraco-abdominal X-ray, revealed air-fluid levels in the small and large intestines (Figure 2). Preoperative laboratory tests showed a hemoglobin level of 12.3 g/dl, a white blood cell count of 18,000, negative C-reactive protein, and normal renal function and electrolyte levels. A diagnosis of complicated left inguinoscrotal

hernia with obstruction was made, indicating the need for surgical intervention. The patient was taken to the operating room under general anesthesia, in a dorsal position. A direct inguinal approach through a short incision in the lower left abdominal fold was performed, noting spontaneous reduction of the hernia at the time of incision. Upon opening the hernia sac, exploration revealed the distal portion of the appendix (Figure 3), which appeared normal. The remainder of the exploration did not reveal bowel ischemia, but a tender testicle. The surgical procedure involved ligating the hernia sac and preserving the appendix. Postoperative recovery was uneventful, with a 5-month follow-up period.

Discussion

The Amyand's hernia is named after the surgeon who first described it in an 11-year-old child in 1735 [1]. It is defined by the

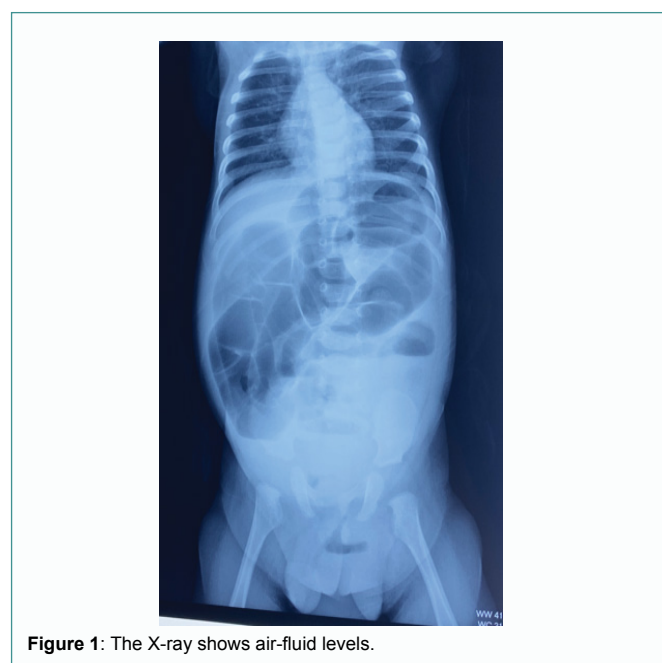


Figure 1: The X-ray shows air-fluid levels.

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Figure 2: Clinical Picture.

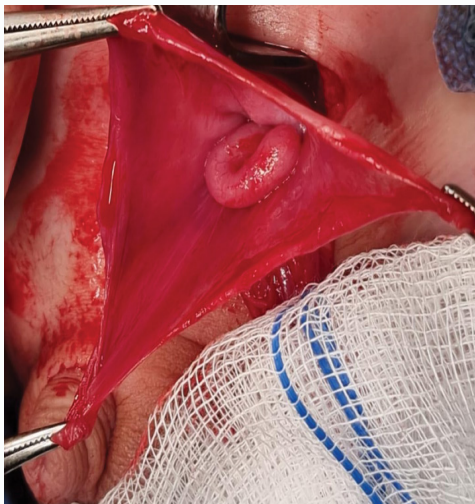


Figure 3: Intra Operative Image.

presence of an inflamed or non-inflamed vermiform appendix within an inguinal hernia sac. Although it is often noted on the right side, it can also be found on the left. This may occur in cases of situs inversus, intestinal malrotation, mobile cecum, or an excessively long vermiform appendix [4-7]. In our patient, the appendix was found on the left side with excessive length and a mobile cecum.

The diagnosis of Amyand's hernia is often made intraoperatively by the observation of a vermiform appendix within the hernia sac, whether inflamed or not. This is because it is rare to perform paraclinical examinations for an inguinal hernia.

The intervention involves an appendicectomy and resection followed by closure of the hernia sac [8-9]. In a study published by A. Morales-Cardenas et al., the intervention involves ligating the hernia sac while preserving the appendix, with no observed complications [10]. Our patient underwent this procedure with ligation of the hernia sac and preservation of the appendix, and experienced a favorable outcome.

Conclusion

Left-sided Amyand's hernia is a rare condition whose diagnosis is typically made preoperatively. The procedure involves ligating the hernia sac with appendicectomy if an inflamed vermiform appendix is present.

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