

Letters to the Editor

Case report: Amyand's hernia, diagnosis to consider in a routine procedure

Key words: Amyand's hernia. Inguinal hernia. Inguinal hernioplasty.

Dear Editor,

The presence of the vermiform appendix in the sac of an inguinal hernia was defined first by Claudius Amyand, an English surgeon eighteenth century, who described the case of an 11-years-old child in which he practiced for the first time an appendectomy for acute appendicitis found in an inguinal hernia (1). Here, we report the case of a patient in who was found an Amyand's hernia while performing an inguinal hernia repair electively.

Case report

We present a 71-years-old male patient admitted for an elective surgery of right inguinal hernia. The patient had history of ischemic heart disease, hypertension, and atrial fibrillation under anticoagulation treatment. During dissection of the hernia sac, a tubular structure corresponding to the appendix with no inflammation signs was discovered. Under strict protection of the surgical borders, appendectomy was performed; hernia sac was closed and reduced into the abdominal cavity. Precleaning the surgical field and changing instrumental and gloves, the hernia was repaired with prosthetic material. The postoperative period was uneventful and the patient was discharged 48 hours after

surgery. In the subsequent tests, the patient reported having submitted wound complications and no signs of recurrence of the hernia were evident.

Discussion

Amyand's hernia, defined as the finding of the appendix vermiform in the sac of an inguinal or femoral hernia, is an uncommon finding with an incidence of 1% (2-5). More exceptionally, the hernia is complicated by acute appendicitis. Its incidence varies from 0.13-1% according to different studies. D'Alia et al. described a single case of Amyand's hernia complicated appendicitis in a review of more than 1,300 cases of hernias interventions (3). In most cases, it is a finding on the operating table, since the diagnosis of incarcerated or strangulated hernia, whereby intervention arises, typically not requires diagnostic imaging tests. The treatment of this type of hernia is guided by

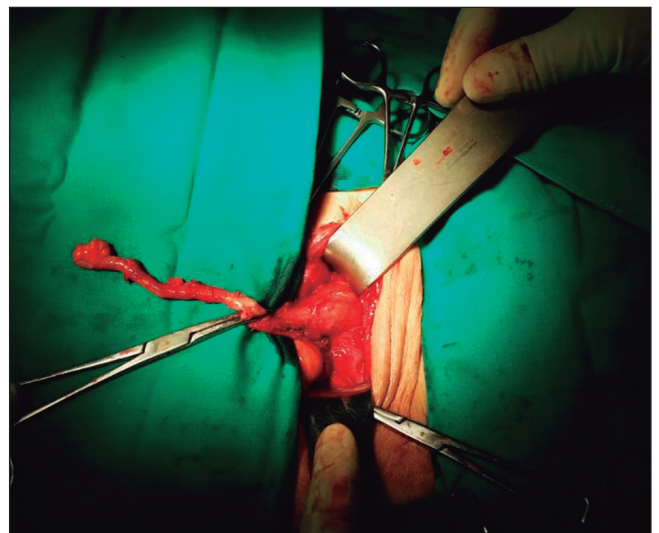


Fig. 1. Vermiform appendix in the sac of an indirect inguinal hernia.

the classification established by Losanoff and Basson (3,4) which describes 4 different types: Recommended appendectomy and hernioplasty in type 1, where the appendix is normal. For type 2 and 3, which have already appendicitis with or without peritonitis, respectively, it is recommended appendectomy through herniotomy or laparotomy, with primary closure of the hernia with techniques without making use of synthetic meshes. Finally, in type 4, laparotomy is indicated and coexisting abdominal pathology must be identified and treated with hernia repair with no prostheses. There seems to be agreement on the therapeutic strategy in the case of complicated appendicitis in Amyand's hernia; however, prophylactic appendectomy in case of incidental finding during an elective intervention is controversial. Those who defend appendectomy argued that careful resection avoiding field contamination would prevent morbidity, mortality, and cost of future appendicitis without increasing the anesthetic risk (1). On the other hand, critics of prophylactic appendectomy, argue that the violation of aseptic surgical technique of a clean procedure increases morbidity from infectious complications, which also increase the likelihood of recurrence of hernia (4).

In conclusion, Amyand's hernia is a rare entity that is generally an unexpected intraoperative finding. The decision to perform prophylactic appendectomy, as in our case, must take into account individual factors that may increase morbidity in a short, medium or long term future.

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