Sir,

Giant inguinal hernias are defined as hernias that extend below the midpoint of inner thigh in standing position and they present formidable surgical challenges in their management.1,2 Morbidity and mortality associated with their repair is high.1,2 These are common in old males doing heavy work and ignoring their disease. In giant hernia, a significant portion of the abdominal viscera is no longer within the abdominal cavity and resides within the large hernial sac which acts as second abdomen. When most organs in the hernia sac create a second abdominal cavity, this can result in abdominal compartment syndrome after reduction of the sac content.3 An abdominal compartment syndrome leading to respiratory and circulatory collapse and multi-organ failure can be the result of such an attempt. Furthermore, the diaphragm will also be displaced into the thoracic cavity resulting in respiratory difficulty and compromised venous return. The replacement of the intestine in the abdominal cavity may also lead to intestinal obstruction.4 The management of giant inguinal hernias present a major challenge and can lead to potentially fatal complications. Adequate pre-operative preparation and close postoperative monitoring and ventilation are essential.

A 62 years old male presented with a huge left inguinoscrotal swelling for the last 10 years (Figure 1). He was having symptoms of difficulty in walking and dragging sensation in the left inguinoscrotal region. The patient was planned for hernioplasty and one stage operation was planned for him. During operation, it was discovered that nearly the whole of the small bowel was found inside the hernial sac with interloop adhesions at some places (Figure 2). After adhesiolysis, the whole small bowel was reduced into the peritoneal cavity with lot of efforts. It was a direct inguinal hernia and the whole of the posterior wall of the inguinal canal was missing and involved in the hernia formation. The posterior inguinal wall was repaired after closing the peritoneum and a large sized polypropylene mesh was used for hernioplasty. The excess scrotal skin was excised and orchidopaxy was performed. Postoperatively, the serum creatinine level rose to 2.6 on the second postoperative day and the intra-abdominal pressure rose to 15 mmHg with increase in the abdominal girth by more than 8 cm pre-operatively. Nasogastric aspiration was done hourly and proper hydration with normal saline was given to the patient along with diuretic support. Patient was kept in the intensive care department of the hospital for about a week. Prokinetic medication in the form of injection metoclopramide 10 mg eight hourly was started on the second postoperative day to enhance bowel motility. The patient started passing flatus on the third postoperative day and the intra-abdominal pressure began to fall by that time along with a decrease in the serum creatinine level was normal and although the abdominal girth was more than before operation, the patient did not have any complaints other than slight sensation of fullness.

Giant inguinoscrotal hernias are uncommon and present a major challenge in management. The management options for large inguinal hernias can be grouped into either enlarging the abdominal cavity or debulking the abdominal contents. Splenectomy, omentectomy, small or large bowel resections can be optional if debulking of the abdominal contents are necessary. These procedures are often combined and contribute to long operative times and usually necessitate intensive care admission and postoperative ventilation.

REFERENCES


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