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## Study of Giant Hernia Surgical Management: A Case Report

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### Abstract

Massive inguinoscrotal hernias extending below the midpoint of the inner thigh, in the standing position constitute giant inguinoscrotal hernias. We report a patient who presented with giant right inguinal hernia of 43 year/Male. He had no past surgical history. He was taken up for surgery under general anesthesia after preoperative respiratory exercises. Sliding hernia with entire greater omentum, small bowel, and appendix as contents was identified. Meshplasty after omentectomy and appendisectomy were done. Giant inguinoscrotal hernias pose significant problems while replacing bowel contents because of the increase in intraabdominal and intrathoracic pressures. Recurrence is another complication seen after successful surgical management. Various techniques such as preoperative pneumoperitoneum, debulking abdominal contents with extensive bowel resections, or omentectomy and phrenectomy have been tried. Postoperative elective ventilation is also needed in many cases. We describe simple reduction with omentectomy as a viable technique in this patient.

**Keywords:** Giant hernia, inguinal hernia, surgical management

### Introduction

Giant inguinoscrotal hernias are defined hernia reached the mid-level of thigh when patient stands. These hernias are rare and usually the result of neglect or fear of surgical procedures. These massive hernias pose significant problems resulting from increase in intra-abdominal pressure during replacement of herniated viscera in order to manage these complications, techniques such as debulking, phrenectomy, have been described. Here, we present a patient with giant inguinoscrotal hernia where simple reduction with omentectomy was successful, and we review the literature.

### Epidemiology

Inguinal hernia incidence rate is 10%. Inguinal hernias are the most common type in both males and females; approximately 25% of males and 2% of females have an inguinal hernia over the course of their lifetime.

### Conceptual Study: Case Study

- **Patient Details**
  - **Age/Sex:** 46-year-old Male
  - **Chief Complaints:** Persistent intermittent pain in the right lower abdomen for the past four months, worsening with movement.
  - **Duration of Symptoms:** Four months

### • AIM

The article aims to:

- Present the clinical details of giant inguinal hernia.
- Discuss the diagnostic approach by clinical examination and investigation
- Review treatment and surgical methods.
- Highlight the role of early diagnosis in preventing complications.

### Objectives

To study the surgical management of Giant inguinal Hernia.

### Material and Method

- Name-ABC
- Age-43yr/Male
- Occupation-bus conductor

### Complaints

The patient reported experiencing localized pain in the right lower quadrant of her abdomen, which intensified with physical activities like lifting heavy objects and long periods of standing. The pain was intermittent but worsening with movements. The patient also noted occasional swelling in the same region. The pain was not associated with gastrointestinal disturbances, such as nausea, vomiting, or changes in

### Past History

S/H/O-No  
No major illness

K/C/O-No K/C/O DM/HTN/IHD/BA/KOCH'S/Thyroid Disorders.

### Family History

- No known family history of hernias or abdominal wall weaknesses.
- No hereditary disorders reported.

### Physical Examination

- G. C-Fair
- P-82/min
- BP-140/90 mmHg.
- CVS-S1S2 N
- CNS-Conscious & Oriented
- RS-AEBE clear
- P/A-Tenderness in right iliac region
- Bowel-PASSED
- Motion-CLEAR

### General Examination

- Pallor, Icterus-Not seen
- No regional Lymphadenopathy
- The patient was in overall healthy, with no significant systemic complaints aside from the abdominal pain and swelling.

### Local Examination

- **Inspection:** Prominent swelling or bulge was observed on initial inspection at right scrotal region
- **Palpation:** Tenderness was elicited on deep palpation in the right lower quadrant of the abdomen. A huge, non-reducible mass was palpable upon Valsalva maneuver, suggesting giant hernia
- **Percussion and Auscultation:** Normal bowel sounds were present. There was no evidence of bowel obstruction or distention

### Investigation

Hb-14.7gm % WBC-7320/Cmm RBC-4.05Mill/cmm  
 PLT-2.77LAKH/CMM BSL{R}-113 mg/dl Sr Creat 0.8mg/dl  
 BUL 33mg/dl HIV & HbSag-Negative

### Ultrasonography (USG)

Initial ultrasonography of the abdomen was performed to assess the abdominal wall structures. This may suggest right inguinal non reducible indirect hernia with the content of small bowel loops, omentum and appendix. Kindly co-relate with clinical co-relation.

### Treatment & Management

i). **Surgical Procedure:** The surgical steps involved:

- **Preoperative Procedure**
  - Fitness done, NBM, Bath, Consent, Inj XST, Prepare,
  - Inj Monocef Igm IV BD
  - Inj Pan 40mg IV BD
  - Inj Emset 4mg IV stat
  - Inj Atropine 0.64mg IM ½ hr prior to Sx.
  - I/V/F RL 1pint IV slowly

### • Intraoperative Procedure

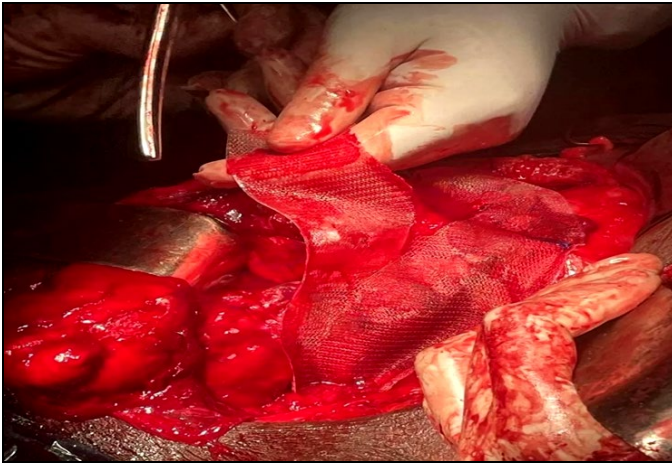
- Anaesthesia-SA Position supine
- Under all aseptic precautions painting and draping done.
- Right Inguino scrotal oblique Incision taken with blade no. 22
- Layerwise dissection done-skin-subcutaneous fat (fascia camper and scarpa)-External oblique muscle-after Splitting it-sac identified
- All adhesions separated from the surrounding structures and separated from the scrotal sac
- Hernia contents i.e. bowel loops tied to reduce through the defect but it was not possible due to small defect
- So left paramedian incision taken
- Layerwise separation done
- All bowel loops and omentum were redeposited into the abdominal cavity
- Omentectomy done
- Appendix identified in hernial content so appendisectomy done
- Posterior wall repaired with help of prolene 1
- Mesh fixation done with prolene 1-0
- Romovac drain no 12 kept in right inguino-scrotal region fixed with mersilk 1-0 then closed with vicryl 2-0
- Layerwise closure done
- Dressing done



Fig 1: Patient with Case of Giant Hernia



Fig 2: Layerwise dissection and reducing herniated content



**Fig 3:** Meshplasty



**Fig 4:** Layerwise Closure

### Conclusion

Giant inguinoscrotal hernias are rare and preoperative diagnosis helps in cardiorespiratory compromise, careful intraoperative reduction of hernia contents, and proper postoperative management can reduce the incidence of hernia recurrence rates.

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### • Postoperative Care

- NBM for 6hrs-sips of water-liq Diet-soft
- Inj MONOCEF 1 gm IV BD
- Inj PAN 40 mg IV OD
- Inj PCM 1gm IV Stat
- Inj TT gm 0.5 cc IM stat
- IVF RL DNS & D5% IV Slowly
- W/F P, BP, SPO2 1/2 hrly. Inform sos.
- The patient was kept in held position for 24 hours
- Advised to avoid strenuous activities for the next four weeks and abdominal binder for three months.
- Analgesics were provided for pain management.
- Scrotal support for 3 month

### Discussion

Giant hernias are often easy to diagnose due to their unique location and the presence of a visible bulge. The patient's persistent pain, the hernia initially apparent on physical examination. Diagnostic imaging, USG and CT scan, played a key role in identifying the hernia and its characteristics.

Surgical intervention is the gold standard for treating inguinal giant hernias, especially when symptoms are present, or complications are anticipated. Hernia repair with mesh reinforcement offers several advantages, including shorter recovery time, reduced postoperative complication, and a lower risk of recurrence. In this case, the patient's surgical outcome was better, with no recurrence or complications during follow-up.