



Ovary, Fallopian Tube And Rudimentary Uterine Horn In An Adolescent Inguinal Hernia - A Rare Case Report.

MANIVANNAN V

Department of General Surgery, STANLEY MEDICAL COLLEGE AND HOSPITAL

Abstract : Abstract A 13 yrs old female Ms.Rajalakshmi admitted with complaints of swelling in the left groin for past 1yr, insidious in onset, gradually increased in size. On examination a swelling in the left inguinal region of size 43 cms, oval in shape, extended from mid-inguinal point to pubic tubercle, Cough impulse was present, Soft in consistency, Deep Ring Occlusion Test- Positive, Three finger test Impulse felt in the index finger. Intra Op Findings were Ovary, Fallopian Tube And Rudimentary Horn Of Uterus In the Posterior Part Of Indirect Hernia Sac. Diagnostic Laparoscopy confirmed Mullerian Duct Dysgenesis.

Keyword : Adolescent sliding indirect Inguinal Hernia, Mullerian Duct Dysgenesis, Canal of nuck.

INTRODUCTION:

Although sliding indirect inguinal hernias containing the ipsilateral ovary and fallopian tube are not uncommon in infant girls, sliding hernias containing uterus with ovary and fallopian tube are extremely rare. The incidence of Congenital Hernia in females is 12%, often indirect inguinal. The Processus vaginalis normally closes at 7th month of gestation. Failure of obliteration results in hernia (if complete persistence) or hydrocele of canal of nuck (if narrow opening). Congenital Hernia is more common in the right side, but occurs bilaterally in 20%. About 40% of inguinal hernia in females have a sliding component. The contents of sliding hernia in females can be uterus and its appendages, appendix or bladder. The risk factors for Congenital hernia include Increased intra abdominal pressure (Repair Of Exomphalos Or Gastroschisis, Severe Ascites, Meconium Peritonitis), Increased peritoneal fluid (Ascites, VP Shunt, Peritoneal Dialysis), Connective tissue disorders (Ehlers-Danlos Syndrome, Hunter-Hurler Syndrome, Mucopolysaccharidosis).

CASE REPORT:

History : 13 yrs old Ms.Rajalakshmi admitted with complaints of swelling in the left groin for past 1yr, insidious in onset, gradually increased in size & attained the present size. No H/O pain in swelling, No H/O chronic cough, constipation or difficulty in micturition. Past history-no comorbid illness, no previous surgery, Birth history- FTND, Menstrual history- not

attained menarche, Family history- none of the family members had similar complaints. General Examination: Patient is moderately built and nourished, conscious, oriented, no pallor, not jaundiced, no cyanosis, no clubbing, no generalised lymphadenopathy. Vitals: PR-88/min, BP-110/70 mmHg, Temperature -Normal. SECONDARY SEXUAL CHARACTERS PRESENT. SPINE & CRANIUM NORMAL Local Examination of Left Inguinal Region: INSPECTION swelling in left inguinal region of size 4*3cms, oval in shape, extends from mid-inguinal point to pubic tubercle, Skin over swelling normal, Cough impulse present PALPATION No Warmth, No Tenderness, Inspectory Findings Confirmed, Consistency- Soft, Deep Ring Occlusion Test- Positive, Three finger test: Impulse felt in index finger. Examination of Right Inguinal Region: Normal.

INVESTIGATIONS:

C B C - W N L ,
CXR, ECG- normal.

DIAGNOSIS:

Congenital Left INDIRECT INGUINAL HERNIA.

SURGERY:

Open herniotomy was done. The exploration of the inguinal canal revealed a large hernial sac with firm mass as its contents. After mobilisation, the hernia sac was opened and to our surprise it contained ovary, fallopian tube and rudimentary horn of uterus in posterior part of indirect hernia sac with wide internal ring admitting tip of little finger. Contents are dissected from the sac and reduced in to the abdomen, after reduction high ligation of sac at internal ring done. As the internal ring is large, it is made small with suturing transversalis fascia with absorbable suture. Conjoint tendon and inguinal ligament are approximated with prolene sutures.





DIAGNOSTIC LAPROSCOPY

Mullerian duct dysgenesis confirmed.

DISCUSSION:

In pediatric age group inguinal hernia results from an incomplete closure of processus vaginalis. During this time, the processus vaginalis is accompanied by the round ligament of the uterus and passes through the inguinal canal up to the labium majora. If the duct remains patent, it is termed as canal of Nuck(1). The patent canal of Nuck may allow the ovary and fallopian tube to enter the inguinal region but the presence of the uterus as its content is very unusual. The presence of the uterus may be found in association with other disorders of sexual development(2). The diagnosis is usually clinical and rarely requires any evaluation. The imaging modality is not a routine in our setup for congenital inguinal hernia, but many authors recommend it in cases of palpable movable mass in the groin of infants (3). However in certain cases even the sonographic pre operative evaluation may be misleading(4). A sliding inguinal hernia is usually diagnosed intra operatively rather than pre operatively. On an extensive search, five cases of indirect hernia containing the uterus, ovaries and fallopian tubes have been reported in the literature, all located on the left side similar to our case. The anatomical abnormality of this entity remains unknown due to small number of cases reported in the literature. There is no specified surgical procedure for indirect inguinal hernia containing uterus and adnexa. However in our case after reduction of the contents we plicated the internal ring to prevent any recurrence. The girl requires close follow up and gynaecological consultation.

CONCLUSION:

Congenital inguinal hernia containing uterus, ovary and fallopian tube is extremely rare. The case is presented due to its rarity of presentation.

REFERENCES:

1. George EK, Oudesluys et al. Inguinal hernias containing the uterus, fallopian tube and ovary in premature female infants. J pediatric 2000;136:696-8
2. Ahdoot M, Qadan et al. Indirect inguinal hernia with uterine tissue in a male: A case of persistent mullerian duct syndrome and literature review. Can Urol Assoc J. 2013;7:E121-4.
3. Narci A, Korkmaz M et al. Preoperative sonography of non reducible inguinal masses in girls. J Clin Ultrasound. 2008;36:409-12.
4. Ming YC, Luo CC et al. Inguinal Hernia containing uterus and uterine adnexa in female infants: report of two cases. Pediatr Neonatol. 2011;52:103-5.

