

Massive Bilateral Inguinal Hernia Repair

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Case Presentation

KB is a 58-year-old male with a history of schizophrenia who was referred to the surgical service in early February with concerns for large bilateral inguinal hernias with skin breakdown on the most inferior aspect of his scrotum and loss of abdominal domain. They had been present for many years. He had been seen in the emergency department 8 months earlier by the surgical team, but did not wish to pursue surgical interventions at the time.

Unfortunately, his hernias were now inhibiting his ability to ambulate and wear pants. Furthermore, the skin breakdown at his scrotum was putting him at risk for impending evisceration. The patient was quite distraught by this and agreed to proceed with surgical repair. He had no prior abdominal surgeries and was followed in the community regarding his schizophrenia. Consent for surgery was obtained, and while he was willing to have his repair done, any attempts at optimization, such as progressive pneumoperitoneum or Botox injections, were limited due to the patient's mistrust of the medical system.

Cross-sectional imaging was obtained to clarify the anatomy and hernia contents. In addition to fluid, the left side contained a large portion of his sigmoid colon, while the right-sided hernia sac contained his cecum and terminal ileum. A significant volume of ascites and scrotal edema was also seen.

Multiple surgical approaches were considered, including performing a laparotomy and bilateral TAR, or beginning with a large Pfannenstiel incision, attempting to reduce the hernia contents, and continuing from that point.

Ultimately, he was taken to the operating room, where a large Pfannenstiel incision was made. The left-sided hernia was identified as a femoral hernia. The hernia sac was carefully dissected off the scrotum, and the hernia was carefully pulled into the abdomen. The hernia sac was opened, and its contents (including the sigmoid colon) were reduced. A similar approach was taken on the right side of the inguinal region, but this was noted to be a true indirect hernia.

With the hernia contents placed back in the abdomen, airway pressures rose from 16cm H₂O to 21cmH₂O. Advancement flaps were created by separating the transversalis fascia

medially to gain access to the preperitoneal space of Retzius. 2 large 15 cm X 15 cm microporous polypropylene meshes were then placed in the preperitoneal space, anchoring it to Cooper's ligaments bilaterally. Fascia was closed in layers. The scrotum was then debrided, and healthy skin was sutured back together.

The patient recovered well in the postoperative period. There was a small amount of wound dehiscence noted POD 5 at the base of the scrotum, but the sutures were left in place, and the hospital wound care team carefully monitored BID Wet to Dry dressing changes until the area healed.

The patient was seen in follow-up recently and is extremely grateful for his care as he can now wear pants without issue. There is no recurrence of his hernia.

Discussion Points

1. Opening incision– Pfannensteil incision vs Laparotomy and Bilateral TAR
2. Anesthesia/Surgery intraoperative collaboration – noting when ventilation pressures increase and making necessary adjustments to keep the patient safe
3. Post-operative management strategies – Bedside suture repair and daily wound care vs OR take-back

Why this case should be selected

While an extremely complex anatomical and social situation, this case highlights the necessity of breaking down each case back to the basics of hernia repair and moving forward, a single step at a time. It also shows how being versed in complex hernia repairs offers truly life-changing treatments for individuals who otherwise would be left suffering. This further highlights the necessity of collaborating with other specialties and allied health care in optimizing care for your patients.

Pictures:

Before



After

