



CASE REPORT

Incarcerated hernia following hemiarthroplasty of the hip with Austin Moore prosthesis



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Abstract Various post-operative complications are reported with hip arthroplasty. Acute abdominal complications are rare; however, they are associated with adverse outcomes and increased mortality. In the present study, we report a life-threatening case of incarcerated hernia following hip hemiarthroplasty. We report a rare case of immediately inguinal incarcerated hernia following cemented Austin Moore hemiarthroplasty for femoral neck fracture in an eighty-three years old man. Three recommendations for this critical complication following hip arthroplasty are as follows. First, a pre-operative evaluation must include a history on the development of hernia and a detailed physical examination. Second, incarcerated hernias should be included in the differential diagnosis of acute abdominal pain following hip surgery. Third, a lateral support device should be placed in the appropriate position to prevent excessive pressure on the abdominal wall.

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1. Introduction

Hip fracture is a crucial research topic among elderly patients. As the elderly population grows, the incidence of hip fracture is predicted to increase substantially, particularly in rapidly aging Asian countries.¹ Femoral neck fractures are a common yet serious type of fracture associated with

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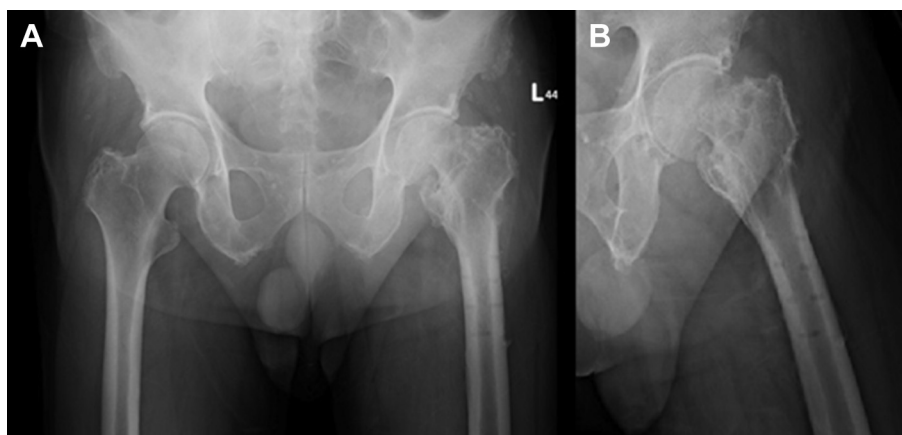


Figure 1 Initial (A) lateral and (B) anteroposterior X-ray images taken at our emergency department show the left femoral neck fracture.

considerable morbidity, mortality, and loss of independence.² Hemiarthroplasty, rather than internal fixation, is considered the gold standard for displaced femoral neck fractures. In elderly patients with displaced femoral neck fractures, cemented unipolar hemiarthroplasty can provide favorable functional recovery and enable early mobilization. Various postoperative complications have been reported in patients who received hip arthroplasty, with elderly patients reportedly having a higher risk of developing these complications.³ Although acute abdominal complications are rare, they are associated with adverse outcomes and increased mortality⁴; some cases of hernia were reported to be associated with total hip arthroplasty.⁵ Here, we report a life-threatening case of incarcerated hernia following hip hemiarthroplasty.

2. Case Report

The patient was an 83-year-old Asian man (68.7 kg, 165 cm; body mass index: 25.2 kg/m²) with multiple comorbidities including diabetes mellitus, chronic heart failure, and a left inguinal hernia. He had undergone Bassini hernioplasty 10 years previously. He had sustained a left intertrochanteric femur fracture and underwent open reduction and internal

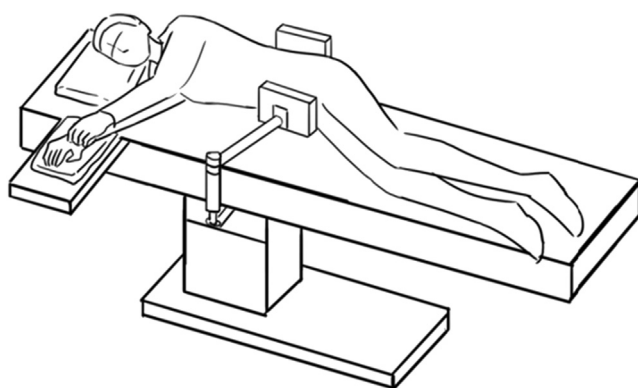


Figure 2 Surgical position used for the Watson–Jones approach. The lateral support was placed against the pubic symphysis.

fixation surgery with a dynamic hip screw 4 years previously; the fracture had united uneventfully. Because of hardware irritation, the implant was removed 3 years later. However, over a 1-month period postoperatively, the patient developed progressive pain and debility in the left hip and presented to our emergency department for further evaluation. Serial imaging and physical examination revealed a left displaced femoral neck fracture (Figure 1). Bilateral inguinal hernias were also noted by CT scan 1 year ago at OPD follow up. After consultation with a general surgeon, conservative management was recommended for the inguinal hernia and a cemented Austin Moore hemiarthroplasty was indicated for treating the displaced left femoral neck fracture.

Following uneventful general anesthesia, the patient was positioned in the right lateral decubitus position, with a rectangular lateral support device attached to his pubic symphysis (Figure 2). A skin incision approximately 7–8 cm in length was created over the hip, extending from the greater trochanter tip to femoral shaft. The hip joint was exposed through partial detachment of the gluteus medius muscle and reverse T-shaped capsulectomy. The fractured femoral head was removed, yielding an appropriate neck length. The bony fragments and loose bodies in the acetabulum were cleaned, and the femoral canal was dilated using a rasp. Next, a suitably sized prosthesis was inserted and fixed using cement. The hip joint was then reduced and its stability was tested. A 1/8" Hemovac was inserted into the hip joint. The capsule and gluteal muscles were repaired, and the wound was closed in layers. The total operative time was approximately 70 minutes, and blood loss was 250 mL. The joint stability and position of the prosthesis were evaluated postoperatively (Figure 3). Postoperative medication included prophylactic antibiotics and oral and intravenous analgesics.

On postoperative Day 1, the patient complained of severe abdominal fullness. Physical examination revealed tympanic percussion and a protruding mass in the left inguinal area. An X-ray of the abdomen revealed gaseous distention of the small bowel loops and the colon (Figure 4). Plasma amylase, lipase, and gamma-glutamyl transferase levels were within normal ranges. Because of the acute onset of abdominal pain with suspected ileus, a general

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