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A case report of a groin pseudocyst following inguinal hernia repair and a review of the literature

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ABSTRACT

INTRODUCTION: Groin hernias are one of the most common general surgery operations performed worldwide and in the United States. We present an exceedingly unusual complication of a patient who underwent a posterior repair of an inguinal hernia.

PRESENTATION: A 48-year-old man presented to our hospital with a chronically enlarging left groin mass for five years following a total extraperitoneal repair of a unilateral inguinal hernia. Two separate aspiration interventions led to rapid re-accumulation of the fluid. Physical exam demonstrated a large inguinoscrotal mass in the left groin. It was non-tender and there were no overlying skin changes. His testicles were palpable at the bottom of the scrotum. A computed tomography exam demonstrated evidence of a prior left inguinal hernia repair. The left groin/scrotum had a 12 cm fluid collection with incomplete peripheral calcification, consistent with previous history of seroma. An indirect hernial sac could not be excluded from the diagnosis. During groin exploration an inguinal canal pseudocyst was removed in its entirety without violating the capsule. The patient recovered well; there was no recurrence at a six month follow up. Review of the literature revealed that only two other cases had been reported, but in contrast to our case, the previous cases had an anterior repair for the index operation and the pseudocysts were open and partly resected.

CONCLUSION: Post-operative inguinal pseudocysts are exceedingly rare. Our case is the third reported in the literature. They can develop following open and laparoscopic mesh repair. Surgical intervention is required for definitive management.

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1. Introduction

Worldwide, over 20 million groin hernias are repaired every year [1]. In the United States alone, groin hernias constitute one of the most common operations undertaken by general surgeons in private practice and academic institutions, accounting for 800,000 procedures annually [2]. Up to 48 billion dollars on health care were the result of cost for caring for patients with groin hernias in 2005 [2]. Therefore, understating all aspects of this operation is important for the general surgeon and the health care provider.

Substantial complications following groin hernia repair are uncommon, but inguinaldynia, recurrence, urinary retention, hematoma and infection are important adverse effects from this intervention [3]. While the use of mesh has considerably reduced the rate of recurrence, unusual complications have emerged from this strategy. For instance, mesh migration is an unusual, but vexing clinical problem [4].

Pseudocysts are distinguished from cysts in that the former lack an epithelial lining [5]. Instead, pseudocysts are characterized by a fibrous rim of tissue that has encapsulated a chronic fluid collection and are common entities following acute pancreatitis [5]. While seromas are common complications of groin hernia repair, a groin pseudocyst is exceedingly rare. In the present report, we discuss a patient who had a pseudocyst after surgical exploration of the inguinal canal and present a review of the literature on the topic.

2. Methods

This is a case report of a patient who presented with this disease at the VA North Texas Health Care System (VANTHCS). The medical records were reviewed for this patient in the computer patient record system. Informed consent was obtained from the patient for the publication of this report. This work has been reported in line with the SCARE criteria [6].

We also undertook a review of the literature to determine if there were previous cases published. PubMed and MEDLINE were searched for relevant articles in the English literature. We also employed Ovid syntax from 1949 to January 2010, the Cochrane Library, Google and Google Scholar.

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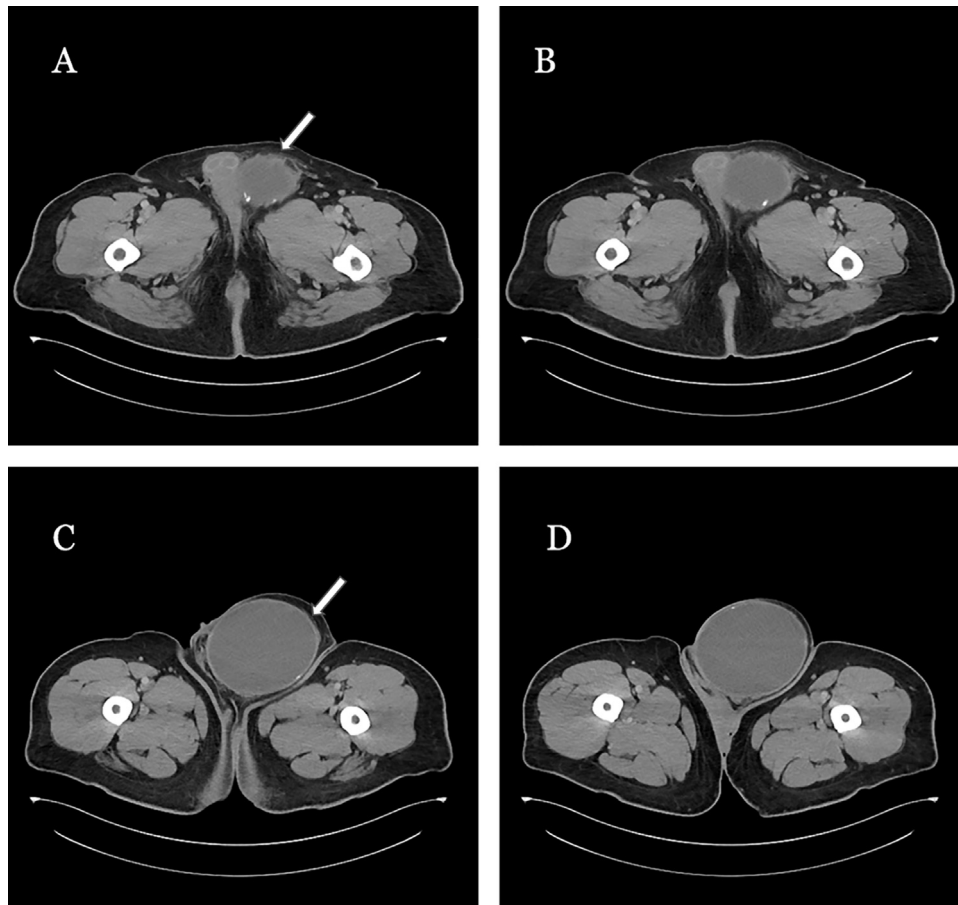


Fig. 1. Computed tomography demonstrating an inguinal canal lesion. There was evidence of a prior repair (panel A; arrow). There is a well-circumscribed 12.0 cm fluid collection. A fibrous capsule vs. hernia sac is demonstrated (panel C; arrow).

2.1. Case report

A 48-year-old man with a past medical history significant for gastroesophageal reflux disease (GERD) presented to the VANTHCS General Surgery service as a consult from the Urology service due to a large left inguinal/scrotal mass that caused him significant discomfort and pain with walking. It also limited his sexual activity. The patient had previously undergone a laparoscopic left inguinal hernia repair (total extraperitoneal approach) with mesh at an outside hospital in 2012. Soon after that surgery, the patient developed a large fluid collection which was aspirated by the general surgeon in charge of that operation on two separate occasions. Unfortunately, the seroma did not resolve. The diagnosis of recurrent left inguinal hernia vs. hydrocele was entertained.

On physical exam, the patient was in no acute distress. His vital signs demonstrated a temperature of 97.9°F (36.6°C), heart rate of 87 beats per minute, and a blood pressure of 132/74 mm/Hg. His cardiovascular and pulmonary exams were unremarkable. His abdomen was soft, non-tender, and non-distended. He had a large inguinoscrotal mass in the left groin. It was non-tender and there were no overlying skin changes. His testicles were both palpable at the bottom of the scrotum.

Laboratory data revealed a hematocrit of 35.5%, hemoglobin of 11.2 g/dL, and a white count of 10.2 K/uL. His creatinine was 0.65 mg/dL, potassium 3.8 mmol/L, and a sodium of 140 mmol/L. His liver function tests were within normal limits.

A computed tomography exam demonstrated evidence of a prior left inguinal hernia repair. The left groin/scrotum had a 12 cm fluid collection with incomplete peripheral calcification, consistent

with previous history of seroma. A small left hydrocele was also observed (Fig. 1). An indirect hernial sac could not be excluded from the diagnosis.

The patient was then taken to the operating room for a left groin exploration with the possible diagnosis of a recurrent left inguinal hernia. In the operating room, a groin exploration was performed by making an incision two thirds of the distance between anterior superior iliac spine and the pubic tubercle. The tissues were then taken down to the aponeurosis of the external oblique muscle. Sharp dissection exposed the cord structures and a Penrose was utilized to obtain circumferential access around these. A 12.0 × 9.0 × 7.0 cm cystic lesion with a well circumscribed capsule was identified and delivered into the wound. The testicles were identified, and we proceeded with exploration of the cord structures to identify the hernia sac. The cystic lesion followed the path of an indirect hernial sac located anterior and medial onto the cord structures. It was unclear if this was a fluid-filled indirect hernia sac. Careful blunt dissection was employed to remove the adhesions of the cystic lesion from the scrotum until the entirety of the cyst was delivered into the wound (Fig. 2, panel A). The cystic lesion was entirely resected from the cord structures and no intraperitoneal connection was found (Fig. 2; panel C). There was no indirect hernia sac and the floor appear to be intact, but weak. We elected to enforce the floor by bringing the conjoint tendon to the shelving edge of the inguinal ligament with 0-polydioxanone (PDS) sutures in a figure of eight fashion. The external oblique aponeurosis was closed with a 2–0 Vicryl suture, the Scarpa's fascia with 3–0 Vicryl and the skin with 4–0 Monocryl. At the end of the operation, 10 mL of 0.25% bupivacaine with epinephrine (1:200,000) was infiltrated

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