Ovarian indirect inguinal hernia: A case report

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A 40-year-old multiparous woman presented to a rural emergency department with acute on chronic right groin pain and an associated lump lateral to her pfannensteil incision. The pain had been intermittent for one year but had become constant a week prior to presentation. She had a past history of three caesarian sections, hysterectomy and appendicectomy. A pelvic ultrasound (US) 3 days prior to presentation revealed a mildly tender right inguinal hernia containing freely mobile multiloculated cystic structure (Fig. 1). A repeat pelvic ultrasound and a computerised tomography (CT) scan pelvis revealed an enlarged right pelvic ovary, adjacent fat stranding and engorged ovarian vessels. No inguinal hernia was visualised (Fig.2).

General surgery and gynaecology were referred for a presumed torted-detorted ovary secondary to incarceration within an indirect inguinal hernia. The ovary was not explored, however she underwent an open inguinal hernia repair with the aim of preventing recurrence.

The patient described relief from her pain and was discharged on day three of admission following an uncomplicated post-operative course. A repeat pelvic ultrasound one week post discharge demonstrated the right ovary in the pelvis with good vascularity.

Inguinal hernias containing female adnexa are rare and occur in 3% of inguinal hernias. Furthermore, they usually occur in the paediatric population or are associated with genital tract anomalies in women. Multiparity may be a risk factor. Early diagnosis with the assistance of Doppler ultrasound may prevent complications such as torsion and infertility. Nonetheless, repair of the hernia may be important for symptom management and prevention of recurrence.

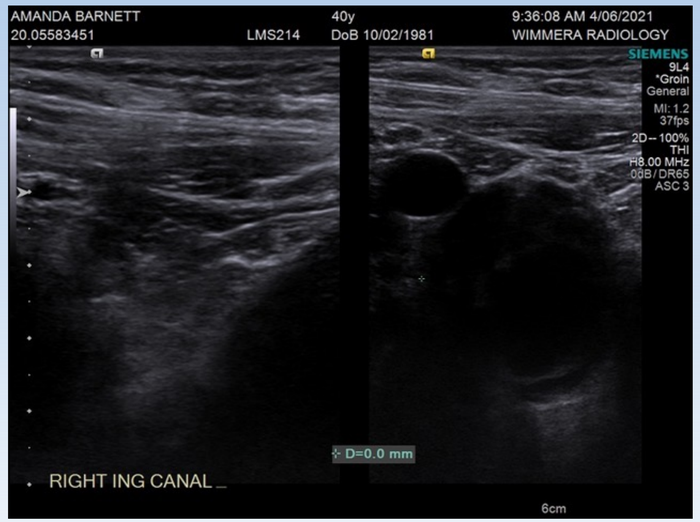


Fig. 1 Initial US demonstrating freely mobile cystic structure in inguinal canal



Fig. 2 CT demonstrating enlarged right ovary with no hernia