

Recurrent gastric outlet obstruction due to an inguinal hernia

V. Naraynsingh, K. Sieunarine and G.C. Raju

Department of Surgery, Port-of-Spain General Hospital, Trinidad, West Indies

Summary: Although gastric strangulation in an inguinal hernia has been reported on three previous occasions, recurrent gastric outlet obstruction due to this hernia has not been previously documented. Prolonged traction on the distal stomach by omentum and transverse colon can draw the antrum and pylorus into the hernia and produce gastric outlet obstruction.

Introduction

It is uncommon for the stomach to be included in the contents of an inguinal hernia. It is quite rare for this viscus to become strangulated in an inguinal hernia; only 3 cases of this have been reported.^{1,2,3} Recently we encountered the rare occurrence of the gastric antrum and pylorus in a long-standing inguinal hernia, which produced recurrent gastric outlet obstruction.

Case report

A 62 year old male presented because of epigastric burning and vomiting. He had a previous admission to hospital 4 months before for the same problem and, following discharge, he continued to have recurrent bouts of vomiting. The vomitus was always 'quite acid' and not bile stained. Although he had a large left inguinal hernia, which had progressively increased in size over the past 20 years, he had had no pain or tenderness in this region. The hernia was irreducible over the last 6 years. He was a well hydrated, afebrile, elderly man with a large irreducible non-tender left scrotal hernia. There was slight abdominal distension, mild tenderness but no masses or free fluid. Chest X-ray and routine blood investigations were normal. A barium meal showed a large stomach extending into the hernia with the distal stomach in the hernial sac. The duodenum seemed to arise from the region of the neck of the sac. Endoscopy showed some inflammation of

the distal oesophageal mucosa, but no ulceration was present in either the oesophagus or stomach. The endoscope could not be passed into the pyloric antrum as the distal body of the stomach was very narrow in the region of the neck of the sac.

Through an inguinal incision, the hernial sac was opened. The entire transverse colon, splenic flexure, descending colon and greater omentum were contained in a sliding hernia in which the sigmoid colon formed part of the sac. The distal body, antrum and pylorus of the stomach were easily visualized. An obvious fibrotic line transversed the antrum at the neck of the sac; this appeared to be the site of previous recurrent obstructive episodes. The hernia was reduced, the testis sacrificed and the internal ring closed. The posterior wall was repaired using nylon and routine closure performed. The patient recovered uneventfully.

Discussion

Progressive descent of the sigmoid colon in this sliding hernia was so extensive that the descending colon, splenic flexure and transverse colon were also pulled into the sac. Long-standing traction on the greater omentum and its attachments, stomach and transverse colon, was responsible for the descent of the distal stomach into the hernial sac.

Although the hernia was the causative factor, the presenting symptoms suggested a separate upper gastro-intestinal pathology with no symptoms referable to the hernial site. In a patient with recurrent gastric outlet obstruction, who has a massive scrotal hernia, the possibility of gastric herniation should be considered.

Correspondence: V. Naraynsingh F.R.C.S. (Ed), 94 Eastern Main Road, Tunapuna, Trinidad, West Indies
Accepted: 9 April 1987

References

1. Gue, S. Spontaneous rupture of the stomach. A rare complication of inguinal hernia. *Br J Surg* 1970, **57**: 154–155.
2. Nagendran, T. Stomach contained in a giant scrotal hernia. *Am J Surg* 1977, **43**: 473–476.
3. Padmanabhan, A.I. & Lowenfels, A.B Letter: An unusual hernia. *JAMA* 1976, **235**: 2813.