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Giant inguinoscrotal hernia

Case history

Mr HB, 69 years of age, presented with a 3 month history of progressive itchy erythematous lesions on his groin. His medical history consisted of hypertension, hyperuricemia and gastric ulcer. He also suffered from a long history of rheumatoid arthritis.

Physical examination revealed a very large scrotal swelling (*Figure 1*). This swelling was separate from the testis, not confined to the scrotum, did not transilluminate, and increased with coughing. Erythematous plaques with an irregular margin and surrounding satellite papules were observed in groin area.

Mr HB said the scrotal swelling had developed many years ago and had gradually become bigger over the past 10 years. He was seen 8 years ago and he declined any surgical intervention at this time. The size of the swelling was now compromising his mobility but he had become so accustomed to it that he felt it was not troublesome. His social life was confined mainly to his home. Mr HB also had difficulty initiating micturition, and experienced urine leakage with subsequent irritation and maceration of the surrounding skin. He denied pain, tenesmus or urgency with urination. Laboratory analyses were unremarkable.

A clinical diagnosis of cutaneous candidiasis was made and radiological tests confirmed the diagnosis of giant inguinoscrotal hernia.

Topical miconazole twice daily was prescribed with resolution of skin symptoms within 4 weeks.

Figure 1. Giant scrotal swelling and bilateral erythematous plaques with an irregular margin and surrounding satellite papules, suggestive of cutaneous candidiasis in the context of a giant inguinoscrotal hernia

Giant inguinoscrotal hernias are uncommon in developed countries.[1] They are defined as 'hernias that extend below the midpoint of the inner thigh in the standing position'. As well as the classic complications of inguinoscrotal hernia, patients will encounter difficulty in walking, sitting or lying down, with mobility dramatically restricted. Patients will also often develop cutaneous complications such as irritative eczema, candidiasis, and gangrene or ulcers. When the ureter or bladder are contained in the hernia's sac, recurrent urinary tract infections may also occur.

Clinical and differential diagnosis

Patients may present with difficulty initiating micturition or acute retention of urine due to voiding difficulties as the scrotum tightens around the penis.

Other causes of scrotal swelling include testicular tumours, acute epididymo-orchitis, epididymal cysts, and rarely, haematocoeles and gummas. All of these swellings are confined to the scrotum. Testicular tumours usually present as painless lumps arising from and rarely replacing the testis. Epididymo-orchitis usually causes a painful erythematous swelling of the hemi-scrotum. Both the testis and epididymis are swollen and exquisitely tender. An epididymal cyst causes a painless epididymal lump palpable separate from the testis. Gummas and haematocoeles, like tumours, present as painless scrotal swellings, but unlike tumours, the testis and epididymis cannot be easily defined.

Management

Giant inguinoscrotal hernias present formidable surgical problems and the morbidity and mortality associated with their repair are high. Reduction of large herniae can compromise lung function, and patients may have been previously denied surgery because of the risk of respiratory compromise. Potentially fatal cardiorespiratory failure can develop following the reduction of giant herniae, due to the sudden increase in intra-abdominal pressure and elevation of the diaphragm. Postoperative ileus can further increase intra-abdominal pressure.[2]

Giant groin hernia repair implies reintroduction of herniated bowel into the abdominal cavity. A colonic resection is sometimes

required to allow closure of the abdominal wall. Vascular deficit, abdominal compartment syndrome and stretched mesentery may impair colonic vitality and anastomotic integrity.

There are few surgical techniques described in the literature for repairing giant inguinoscrotal hernias. The most common technique requires frequent insufflations of air into the abdominal cavity in order to create space to accommodate herniated viscera and facilitate fascia repair with minimal tension.

For men with minimally symptomatic inguinal hernia who have no hernia related pain or discomfort limiting usual activities or difficulty in reducing the hernia, watchful waiting may be an acceptable option.[3]

Case follow up

The patient felt that his inguinoscrotal hernia did not interfere with his daily life. He was also taking immunosuppressive treatment for rheumatoid arthritis, which could potentially increase surgical and postoperative risks. A conservative approach, paying particular attention to the patient's general condition, was considered an appropriate option.

Conflict of interest: none declared.

References

1. El Saadi AS, Al Wadan AH, Hamerna S. Approach to a giant inguinoscrotal hernia. Hernia 2005;9:277–9.
2. Mehendal FV, Taams KO, Kingsnorth AN. Repair of a giant inguinoscrotal hernia. Br J Plast Surg 2000;53:525–9.
3. Fitzgibbons Jr A, Giobbie-Hurder JO, Gibbs, DD et al. Watchful waiting vs repair of inguinal hernia in minimally symptomatic men: a randomized clinical trial. JAMA 2006;295:285–92.

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