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# An Obstructed Femoral Hernia

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## Abstract

Clinical History and Imaging Procedures

A 78 year old female presented with a 2 week history of abdominal distension, nausea, and vomiting. She had undergone a left total knee replacement 4 weeks previously and had commenced antibiotics for a wound infection 2 weeks prior to admission. Otherwise apart from hypercholesterolaemia there was no other significant past medical history. On examination she was afebrile and routine observations were normal. A tender irreducible lump was present in the right groin. Routine blood investigations were unremarkable apart from mildly elevated inflammatory markers. AXR demonstrated dilated small bowel loops with gas cut off at the right groin. The patient was subsequently taken to theatre and the diagnosis of an obstructed right femoral hernia was confirmed. The small bowel was found to be viable and the hernial sac was closed.

## Discussion

A femoral hernia accounts for approximately 5-10% of all groin hernias in adults. Often, they present with a varying degree of complication ranging from irreducibility through intestinal obstruction to frank gangrene of contained bowel. The incidence of strangulation in femoral hernias is high. A femoral hernia has often been found to be the cause of unexplained bowel obstruction. The diagnosis is largely a clinical one. However in the difficult (obese) patient imaging in the form of ultrasonography, CT, or MRI may aid in the diagnosis. An abdominal x-ray showing small bowel obstruction in a female patient with a painful groin lump needs no further investigation. Femoral hernias like most other hernias need operative intervention.

## CLINICAL SUMMARY

A 78 year old female presented with a 2 week history of abdominal distension, nausea, and vomiting.

## CLINICAL HISTORY AND IMAGING PROCEDURE

A 78 year old female presented with a 2 week history of abdominal distension, nausea, and vomiting. She had undergone a left total knee replacement 4 weeks previously and had commenced antibiotics for a wound infection 2

weeks prior to admission. Otherwise apart from hypercholesterolaemia there was no other significant past medical history. On examination she was afebrile and routine observations were normal. A tender irreducible lump was present in the right groin. Routine blood investigations were unremarkable apart from mildly elevated inflammatory markers. AXR demonstrated dilated small bowel loops with gas cut off at the right groin. The patient was subsequently taken to theatre and the diagnosis of an obstructed right femoral hernia was confirmed. The small bowel was found to be viable and the hernial sac was closed.

### Figure 1

Figure 1: AXR showing dilated small bowel loops with 'cut off' at right hernial orifice



### DISCUSSION

A femoral hernia accounts for approximately 5-10% of all groin hernias in adults. The incidence of femoral hernias, male to female, is generally reported to be about 1:4. Most femoral hernias occur in women aged over 50 years especially if parous. They are rare in children and account for about 1% of groin hernias. They typically present as a

groin lump classically lateral and inferior to the pubic tubercle. There may be a cough impulse. They may or may not be associated with pain. Often, they present with a varying degree of complication ranging from irreducibility through intestinal obstruction to frank gangrene of contained bowel. The incidence of strangulation in femoral hernias is high. A femoral hernia has often been found to be the cause of unexplained bowel obstruction. The diagnosis is largely a clinical one. However in the difficult (obese) patient imaging in the form of ultrasonography, CT, or MRI may aid in the diagnosis. An abdominal x-ray showing small bowel obstruction in a female patient with a painful groin lump needs no further investigation. Femoral hernias like most other hernias need operative intervention. All uncomplicated femoral hernias should be repaired as an elective procedure. However because of the high incidence of complications (strangulation in 40%) femoral hernias often need emergency surgery. Three classic approaches to the femoral canal have been described: low(Lockwood), transinguinal (Lotheissen), high(McEvedy). Irrespective of approach used the following will be achieved; dissection of sac, reduction/inspection of contents, ligation of sac, and approximation of inguinal and pectineal ligaments.

### References

1. Fundamentals of surgical practice A.A. Majid, A.N.Kingsnorth
2. Hair A, Patterson C, O'Dwyer PJ; Diagnosis of a femoral hernia in the elective setting; J.R.Coll.Surg.Edinb., 46, February 2001, 117-18
3. Kingsnorth A N. Inguinal hernia repair. Current Practice in Surgery 1993; 5: 202-206
4. Thomas P. Decision making in surgery: Operative management of a strangulated femoral hernia. Br J Hosp Med 1993; 49 : 432 - 433
5. Working Party of the Royal college of Surgeons. Clinical guidelines on the management of groin hernias in adults. RCS London 1993

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