



CARTA AL EDITOR

A MYAND HERNIA – A CHALLENGING CONDITION

Vitorino Modesto dos Santos^{1*}, Lister Arruda Modesto dos Santos²

¹ Santos VM, MD, PhD. Adjunct-professor of Internal Medicine, Armed Forces Hospital, and Catholic University of Brasília-DF, Brazil.

² Santos LAM, MD. Preceptor. Advanced General Surgery and Oncosurgery of IAMSPE, São Paulo-SP, Brazil. C.

Dear Editor,

The Amyand's hernia (AH) was first described and treated by Claudius Amyand in 1736, and is characterized by the presence of the appendix in the right or left inguinal hernia sac. (1-6) AH is classified as: type I) when the appendix is normal; type II) when there is infection limited to hernia sac; type III) when the infection extends beyond the sac; and type IV) when there are other associated benign or malignant conditions. (1-6)

We read the report of a 55-year-old male patient with an irreducible type III AH (presenting with local inflammatory changes besides the Blumberg sign), and who underwent the successful hernial sac opening and resection of the inflamed appendix. (1) The authors highlighted the suspicion index about this surgical condition in patients with manifestations of a complicated right inguinal hernia without intestinal occlusion; and,

Autor de correspondencia:

Prof. Vitorino Modesto dos Santos
vitorinomodesto@gmail.com

Recibido: 04/12/2023

Aceptado: 11/12/2023

the appendectomy and wall reparation avoiding the inguinal canal contamination. (1) The aim of the following short comments on recent literature is enhancing the awareness and the suspicion index of primary care workers about this rare challenging condition, including two articles on left-sided AH, which increase the diagnostic conundrum. (5-6)

Crăciun C, et al. described a 77-year-old man with incarcerated inguinoscrotal hernia, perforated phlegmonous appendicitis, besides a septic process involving portions of the ilium, caecum, ascendant colon, and the right testicle within the hernia sac. (2) Hemicolectomy, orchiectomy, and herniorrhaphy without a mesh were performed, and with uneventful postoperative period, the patient was discharged to home after a week. The authors emphasized the size of the hernia sac ruling out the laparoscopic option. (2) Radboy M, et al. reported a 48 year old male with a type 1 right AH confirmed by abdominopelvic ultrasound images of the inflamed appendix partially herniated into the inguinal canal from a small sac, which were easily managed by laparoscopic surgery. (3) The authors cited the procedures for with each AH: type 1) reduction of hernia and mesh repair; type 2) appendectomy and hernia repair without mesh; type 3) laparotomy and appendectomy and hernia repair without mesh; and type 4) laparotomy and appendectomy and hernia repair without mesh, plus control of the abdominal disease. (3) Riojas-Garza A, et al. described a 57-year-old man with AH, perforated appendicitis and a giant inflamed sigmoid diverticulum revealed by the preoperative tomography scan; the patient had a Hartmann's procedure, appendectomy and a non-mesh hernia repair; the authors emphasized the very uncommon association of AH with acute diverticulitis. (4) In the scenery of exceeding rare cases related to AH, one should consider the following examples of this condition that were diagnosed at the

left side of abdominal cavity. (5,6) Corvatta FA, et al. reported a 72-year-old female with a complicated left inguinal hernia, who had a large direct hernial sac containing the normal cecum and appendix, and a concomitant femoral hernia with the larger omentum slipped into the femoral canal. (5) Due to the large size, the McVay technique was utilized for the primary closure, and the hernioplasty was performed utilizing a polypropylene mesh without any complications. The authors emphasized that this was the first case study about a left-sided AH coexistent with an ipsilateral femoral hernia that was found during the emergency hernioplasty. (5) Jha S, et al. described a 66-year-old man with a long-standing left-sided inguinal hernia recently causing abdominal pain, vomiting, and irreducible inguinoscrotal swelling. (6) The laparotomy with opening of the hernia sac were able to show normal appendix and omentum, the caecum presenting a perforation, and the evidence of fecal peritonitis; then, the authors stressed that this case did not fulfill any of the four classical AH types. (6)

Conflictos de interés:

Los autores declaran no tener conflictos de interés.

REFERENCIAS BIBLIOGRÁFICAS

1. Ferreira R, Giubi J, Villagra R, Colucci A. Hernia de Amyand. Reporte de caso. *Discov Med.* 2023;7(1):69-72. [PMID:16937454 DOI: 10.3748/wjg.v12.i29.4761]
2. Crăciun C, Mocian F, Crăciun R, Nemeş A, Coroş M. Perforated appendiceal mucocele within an Amyand's hernia: A case report and a brief review of literature. *Chirurgia (Bucur).* 2023;118:1. [PMID: 37750318 DOI: 10.21614/chirurgia.118.eC.2740]
3. Radboy M, Kalantari ME, Einafshar N, Zandbaf T, Bagherzadeh AA, Shari'at Moghani M. Amyand hernia as a rare cause of abdominal pain: A case report and literature review. *Clin Case Rep.* 2023;11(10):e7929. [PMID: 37780933 DOI: 10.1002/ccr3.7929]
4. Riojas-Garza A, Hinostroza-Sanchez MA, Gutierrez-Cerda M, Gutierrez-Gandara P, Anguiano-Landa L, Estevez-Cerda SC. Amyand's hernia in a patient with acute complicated diverticulitis. A case report and review of the literature. *Int J Surg Case Rep.* 2023;112:108972. [PMID: 37883877 DOI: 10.1016/j.ijscr.2023.108972]
5. Corvatta FA, Palacios Huatuco RM, Bertone S, Viñas JF. Incarcerated left-sided Amyand's hernia and synchronous ipsilateral femoral hernia: first case report. *Surg Case Rep.* 2023;9(1):15. [PMID: 36723671 DOI: 10.1186/s40792-023-01597-9]
6. Jha S, Kandel A, Baral B, Ghimire P. Perforated caecum in a left-sided Amyand's hernia: A case report. *JNMA J Nepal Med Assoc.* 2023;61(260):387-389. [PMID: 37208884 DOI: 10.31729/jnma.8114]

