Several studies\textsuperscript{1,2,3,4,5,6,7,8,10,11} report different variations. The most representative of them is to Hiatt et al\textsuperscript{3} with a sample of 1000 people. The variation here presented (common hepatic artery + superior mesenteric artery) is of uncommon occurrence with an average of 2%. This value agrees well with the values found in other articles, ranging from 1.6% to 3.5%.

ACKNOWLEDGEMENTS

The authors thank Priscilla Vieira Ely Hattori, technique laboratory of the Federal University of Grande Dourados (Dourados, Mato Grosso do Sul) for logistical support offered to the writing of this Letter to the Editor.

REFERENCES


INTRODUCTION

The presence of a veriform appendix inside a hernial sac is not a common condition\textsuperscript{7}. In the literature, the reported incidence is around 1% of all hernias\textsuperscript{4}. It is even rarer to find an acute appendicitis inside the inguinal hernia\textsuperscript{4}.

When the cecal appendix, inflamed or not, is found in the inguinal sac, it is called an Amyand hernia\textsuperscript{5}. This kind of hernia is more frequent in men and pre-operative diagnosis is not easy\textsuperscript{3}. It must be suspected in patients with a tense inguinal hernia with no signs of intestinal obstruction. The appendectomy will always be carried out at the same time as the repair of the hernia.

The aim of the present study is to present a case of acute appendicitis within a right inguinoscrotal hernia and to review the literature.

CASE REPORT

A 35-year-old male farmworker arrived at the General Surgery Service of the Hospital Universitário Oswaldo Cruz, Recife, Pernambuco, Brazil. He reported the appearance of a mass in the right inguinoscrotal region for around one month without pain. Two days previously he had begun to experience epigastric pain with nausea and vomiting. He visited his local health service and received treatment for gastritis. As the pain continued and was located in the right iliac fossa, he was admitted to hospital. A physical examination revealed a heart rate of 100 bpm, a respiratory rate of 21 ipm, PA=130x80 mmHg and an inguinoscrotal hernia on the right side with slight irritation of the peritoneum. He was referred for surgery and the procedure revealed an inflamed appendix with purulent secretion at its apex within the hernial sac. As surgical access was by transverse incision of the inguinal hernia, it was decided to perform the appendectomy and the Bassini repair of the hernia simultaneously (Figure 1). Antibiotic prophylaxis with metronidazole and ceftriaxone was carried out for 24 hours. After two days, the patient was discharged from hospital with no complications.
1731. Claudius Amyand (1681-1740), a French surgeon, who was a refugee in England, was the first to perform an appendectomy. The appendix is found in the hernial sac and around 1% of inguinal hernias and an infamed appendix is found in only 0.13% of cases. A variant of this, an appendix inside a femoral hernia, is called a Garengeot hernia. In 1937, Ryan described 11 cases of acute appendicitis (within an inguinal hernia) among 8,692 cases of appendicitis. Another author reported 10 cases of appendicitis within an inguival hernia over nine consecutive years.

The etiopathogenesis of acute appendicitis is unclear. Many authors believe there is an association between incarceration and inflammation of the cecal appendix in the hernial sac, that is, an ischemic phenomenon deriving from compression of the organ by the hernial ring leading to appendicitis. Typical symptoms of acute appendicitis, such as initial epigastric pain settling later in the right iliac fossa, nausea, vomiting and anorexia may also be seen in patients with an Amyand hernia. According to the literature, fever and leukocytosis are not common in these patients. Pre-operative diagnosis is unusual. In an article reviewing 50 cases of Amyand’s hernia, only one case was diagnosed prior to surgery.

The presence of peritoneal irritation and early pain in an incarcerated hernia may suggest appendicitis inside the hernial sac. The use of imaging methods may assist diagnosis. Surgery is mandatory. However, the kind of surgery recommended subject to controversy. In most circumstances, treatment involves an emergency appendectomy and repair of the hernia. When there is a risk of complications, such as a pericecal abscess, the appendectomy should be pre-peritoneal to minimize possible infection of the wound and recurrence of the hernia.

REFERENCES