

CONTINUING MEDICAL EDUCATION ΣΥΝΕΧΙΖΟΜΕΝΗ ΙΑΤΡΙΚΗ ΕΚΠΑΙΔΕΥΣΗ

Medical Imaging Quiz – Case 76

A 50-years-old patient was referred to the Computed Tomography (CT) Department to perform an abdomen CT due to invasive infection. He mentioned past medical history of abdominal pain and constipation. Computed tomography revealed none cause of infection, but revealed an accidental pathological finding that our patient never mentioned (fig. 1).

Comment

Inguinal hernia is the type of groin herniation that occurs above the inguinal ligament and through the inguinal canal. They are the commonest type of abdominal wall herniation and are most often acquired. There is a male predilection with an M:F ratio of up to 7:1. Patients most commonly present with swelling and or pain in the relevant groin, iliac fossa, loin. Men may also have testicular pain.

It is broadly divided into two types: Indirect inguinal hernia (more common) and direct inguinal hernia. Risk factors for indirect inguinal hernia are prematurity and low birth weight, patent processus vaginalis, urologic conditions (e.g. cryptorchidism, hypospadias or epispadias, bladder exstrophy, ambiguous genitalia), abdominal

wall defects (omphalocele, gastroschisis, cloacal exstrophy, bladder exstrophy) and family history.

A direct inguinal hernia is a consequence of weakened abdominal musculature, often brought on by advanced age, strain, previous abdominal surgery. Direct hernias are rare in women since the broad ligament acts as an additional barrier. Surgical treatment options include herniorrhaphy, hernioplasty. Complications, as in any other abdominal wall herniation, include incarceration, strangulation, bowel obstruction. Possible imaging differential considerations include femoral hernia, hydrocele or varicocele.

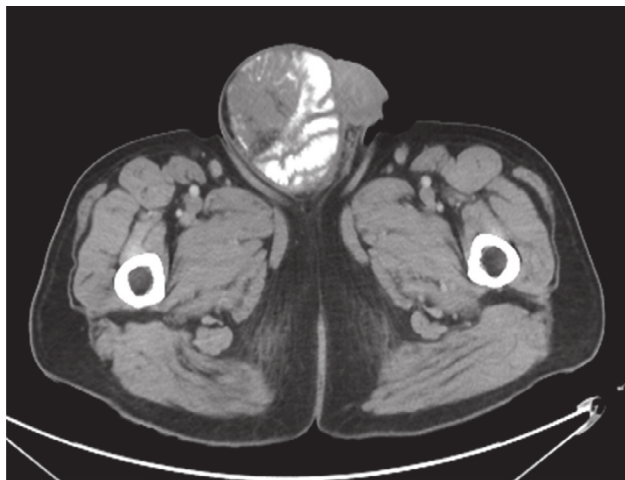


Figure 1. There is a right inguinoscrotal hernia through the inguinal canal, containing small bowel loops with no signs of obstruction or necrosis.

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Diagnosis: Inguinoscrotal hernia