



Case Report

A Giant Scrotal Hernia Case with Erectile Dysfunction

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Abstract

Giant inguinal hernias are extremely rarely seen today, in fact never seen in developed countries, and accurate diagnostic and interventional approaches are of vital importance, given the significant morbidity and the decline in patient comfort that they cause. We present a case of giant inguinoscrotal hernia with a complaint of erectile dysfunction. The patient refused to have treatment due to social pressure related to possible orchiectomy procedure. We believe that sharing such examples primarily in the literature at least in terms of enriching the notion of a national emergency surgery will be a driving force in establishing more effective health policies.

Keywords: Inguinal hernia, giant scrotal hernia, complications.

Introduction

Giant inguinal hernias are rarely seen today, in fact never seen in developed countries, and accurate diagnostic and interventional approaches are of vital importance, given the significant morbidity and the decline in patient comfort that they cause (Chernev2010, Vano-Galvan2009). In this paper, we present a case of giant inguinoscrotal hernia that differs from classical inguinoscrotal hernias in many respects like erectile dysfunction, including urinary retention, skin ulcers, and infections that they induce. We aimed to evaluate the case along with the presentation and medical history in light of the social structure of the Eastern and Southeastern Anatolia regions that have

different dynamics in terms of national emergency surgical practice in particular.

Case Representation

A 74-year-old male patient applied to urology polyclinic with the complaint of erectile dysfunction. The medical history of the patient, who was referred from the urology department to the department of general surgery, revealed that he is experiencing testicular enlargement with pain which he had accustomed to for approximately 10 years, and that he also had a new-onset erectile dysfunction. The medical history also revealed that he was examined by a general surgery physician, diagnosed with inguinal hernia and recommended for surgical intervention.

The patient stated that the physician had explained that he may be encountered with some problems both during and after the operation or even that the testicles maybe need to be removed together with the surrounding skin if needed which had led the patient to renounce from the operation. The patient stated that he was satisfied with the size of testicles and could handle the pain, but he had increased swelling and pain, could not have sexual activity, and had difficulty in urination especially in the last week, and therefore he applied to the urology department. Physical examination and ultrasonography revealed an inguinoscrotal hernia which was prominent on the left side in particular, an enlarged scrotum extending almost up to the level of knee, and an inverted penis into the enlarged scrotum (Figure1-2). Although there were no palpable testicle and penis, we found edematous, rigid, and immobile bulk on palpation. Palpation of the scrotum was quite painful. Medical history showed

that the hernia could be reduced partially to allow at least micturition and coitus, but there have been an increase in the swelling and pain in the last week and a scrotal stiffness which has not allowed the reduction, but clinical investigation of erectile dysfunction and voiding problems could not be performed. The patient without symptoms of ileus had the preliminary diagnosis of strangulated inguinal hernia and was recommended to be hospitalized for examination and treatment. The diagnosis, treatment, and all relevant risks were explained, and the patient was told that he must be operated. The patient stated that he had no hernia and was satisfied with the size of testicles. The patient was informed that the problems related to micturition and coitus are caused by the inguinal hernia and that the other problems cannot be fixed unless the hernia is repaired, that is why he left the hospital refusing examination and treatment.



Figure 1-2: Giant Inguinoscrotal Hernia almost up to the Level of Knee with Inverted Penis and Enlarged Scrotum

Discussion

Giant inguinoscrotal hernias, which are rare condition in developed one, can be simply described as “a hernia that is extending further down the mid-point of the medial side of the thigh.” The patients can present with symptoms such as urinary retention and testicular pain as in our case, and testicular tumors, acute epididymitis, epididymal cyst, or rarely hematocele can be included in the differential diagnosis

(Vano-Galvan 2009). Therefore, inguinoscrotal hernias, as well as urological pathologies, should be kept in mind in such cases.

The treatment is the main point to focus on for giant inguinoscrotal hernias, where extremely specific surgical techniques could be mentioned. Treatment decision should be made depending primarily on the urgency of the cases. In patients who need to be operated under the emergency

indication, priority is given to the removal of necrotic tissues, rather than to the closure of the defect, whereas different techniques are used for elective operations by considering the status of patients (Vano-Galvan 2009) Before discussing these techniques, we find it useful to remind that such cases are the patients who are typically elderly and have comorbid diseases and high risk of postoperative complications (El Saadi 2005, Garavello 2004) . In Ezer et al.'s study conducted in 2011, a postoperative complication rate of 20% and a mortality rate of 3% were reported, which revealed a significant correlation between age and comorbid diseases and postoperative morbidity and mortality (Ezer 2011). Considering that the cases with giant inguinoscrotal hernia are the patients who are typically elderly and have comorbid diseases will provide better understanding of the importance of early diagnosis and early treatment in minimizing morbidity and mortality. We can better understand rationality of conducting preventive health policy instead of a therapeutic one. Also, it is obvious that the probability of operators, who work in the countryside, facing cases diagnosed at this stage will decrease if the necessary educational activities about the self-care of the patients are provided, and subsequently the accessibility of primary health care services is established and the optimal processing of diagnostic and referral systems is ensured in the countryside.

Extremely specific surgical techniques could be mentioned in the treatment of such an inguinoscrotal hernia diagnosed in the final phases, and even finding an intra-abdominal area for the reduction of a hernia of such a large volume emerges as a problem in itself (Coetzee 2011). Forced reduction into the intra-abdominal cavity can be provided with simple herniorrhaphy technique (Tahir 2008), as well as techniques such as creating space by pneumoperitoneum-flap-patch methods (Tahir 2008, Valliattu 2008) or emptying an area by organ resections (Vasiliadis 2010, Patsas 2010) can be applied. Giant scrotal hernia cases with specific morbidities such as renal failure due to

intravesical obstruction, intestinal malrotation, or different surgical approaches have been published in the literature (Savoie 2013) .Our case is the third patient reported by the authors of this paper from the region within a short time. In addition, these cases are just demonstrative examples of a small sample group encountered in the general surgery outpatient clinic of the relevant center. We believe that sharing such examples primarily in the literature at least in terms of enriching the notion of an international emergency surgery will be a driving force in establishing more effective health policies by increasing the awareness among physicians especially young physicians and residents who are supposed to be studying in many different regions of the different countries.

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