Ileovesicocutaneous fistula in a strangulated femoral hernia

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ABSTRACT

BACKGROUND: Femoral hernias are less frequent among groin hernias. Bladder, as a content of femoral hernia, is seen quite uncommonly. The laxity of the bladder wall, its large capacity or the presence of diverticulum can predispose the urinary bladder to get pulled into the femoral hernia. If the blood supply gets compromised, then it can lead to ischemia of the bladder wall. Intestine can get pulled along with the bladder. Resultant ischaemia of bladder may progress to fistula due to accompanying gangrene of bowel.

MATERIALS AND METHODS: A 86 year old lady presented with a right groin swelling. She turned out to have a ileo-vesico-cutaneous fistula in a strangulated femoral hernia. A thorough search was made using PubMed & Medscape; but we were unable to find similar reported case in the literature.

RESULTS: Literature search revealed two cases of urinary bladder diverticulum in femoral hernia but without fistula.

CONCLUSION: Urinary bladder rarely gets entrapped in femoral hernia. It has never happened along with an ileal loop. It requires high index of suspicion for diagnosis with prompt intervention to prevent complication.

Keywords: Femoral hernia, ileovesical fistula

INTRODUCTION

A hernia is caused by the protrusion of a viscus through a weakness in the containing wall. Femoral hernias are less common than inguinal hernias and account for 2-4 % of groin hernias1. Females are three times more likely than men to have femoral hernias. The exact cause of femoral hernias is not known. Most of the times it is thought to be due to weak area at femoral neck. This may be congenital or secondary to straining.

CASE REPORT

An 86 year old lady was admitted with complaint of 5 days of nausea and vomiting in medical ward. The patient was vitally stable and a febrile. On 6th day after admission, she was referred to surgery for discharging swelling in the right groin area. On examination there was a soft swelling in the right groin area. The swelling was painful and mildly tender. There was purulent discharge from the swelling. It appeared to be an abscess in the right inguino-femoral region. The initial urine routine examination on the day of admission was normal. On the next day, she developed diarrhoea. Ultrasonography

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of the abdomen was normal except few loops of small intestine going towards the groin swelling. Plain X ray showed gas shadows without obvious gas fluid levels. Since she improved with conservative management, strangulation or obstruction was not initially suspected. Barium enema was normal. At this stage she was referred to surgery for drainage of abscess. Before shifting to operation theatre, she was catheterised since her urine output was low. On catheterisation, greenish urine was drained. On exploration, she was found to have strangulated segment of distal ileum in the femoral hernia. Along with ileal loops, the dome of the bladder was pulled in the femoral hernia leading to formation of ileo-vesiculo-cutaneous fistula. The bladder was a large, floppy, thin walled bladder. There was no obstruction or any significant dilatation of proximal small intestine. The damaged ileal loop was resected & reanastomosis was done. The bladder was repaired in two layers with excision of the fistulous tract. The skin sinus tract was excised and healthy skin was resutured. Drain was kept and bladder was catheterised for 10 days. There was complete, uneventful recovery. Histopathology showed no inflammatory bowel disease and the fistula was attributed to mechanical effects of hernia.

DISCUSSION

Most of the times, hernias result due to increased intra-abdominal pressure or musculo-fascial
weakness. The femoral hernias are commoner in females and the usual contents are omentum and small intestine. Bladder can be rarely present in femoral hernias and the laxity of its wall or large capacity is thought to be responsible for it. Also at times, bladder diverticula secondary to urethral stricture or bladder neck contracture can predispose urinary bladder to enter the femoral hernia. Bladder diverticula can be obtained more commonly in a perineal hernia. In this case, there was no associated bowel disease which may contribute to the formation of fistula. It appears that due to laxity of the bladder wall with associated large bladder capacity, the bladder wall got pulled in the femoral hernia along with the ileum. There is a possibility of some form of adhesions between the dome and the ileum. The fistula resulted due to the ischemic necrosis of the walls of the bladder and bowel, leading to spontaneous perforation. Due to delayed presentation as discharging swelling, it resulted in strangulation with formation of ileo-vesico-cutaneous fistula. Once the fistula has developed in a femoral hernia, it has to be explored with excision of the fistula, resection of necrosed bowel and end to end anastomosis of the healthy intestines and repair of the femoral defect.

**CONCLUSION**

Urinary bladder with small intestine as a component of femoral hernia is not reported. A high index of suspicion is to be kept to diagnose a complicated femoral hernia so that prompt intervention can be done to prevent the development of such a complicated fistula.

**REFERENCES**

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