

# Bilateral Giant Inguino-Scrotal Hernia Treated with Intraabdominal Mesh Repair + Component Separation + Reduction Scrotoplasty

D. SEKER, Z. ERGUL, C. UGURLU, I UNAL, E. Olcucuoglu, H. KULACOGLU



Dışkapı Yıldırım Beyazıt Teaching and Research Hospital, Department of Surgery,  
Ankara, Turkey.

Dışkapı Yıldırım Beyazıt Teaching and Research Hospital, Department of Plastic and Reconstructive Surgery,  
Ankara, Turkey.

## Background

Giantinguino-scrotalhernia is one of the annoying problems in general surgery not only because of difficulty in repair but also due to postoperative intraabdominal compartment syndrome risk. Lately, some centers have been using abdominal wall component separation technique to overcome this problem. We herein present such a case of bilateral giant scrotal hernia treated with intraabdominal mesh repair + component separation + reduction scrotoplasty.

## Case Definition

59 year-old male patient was admitted with the diagnosis of bilateral giant incarcerated inguino-scrotal hernia (Figure 1).



Figure 1: Giant inguino-scrotal hernia

Abdomino-scrotal CT showed that the hernia sac was larger than %50 of the intra-abdominal volume (Figure 2).

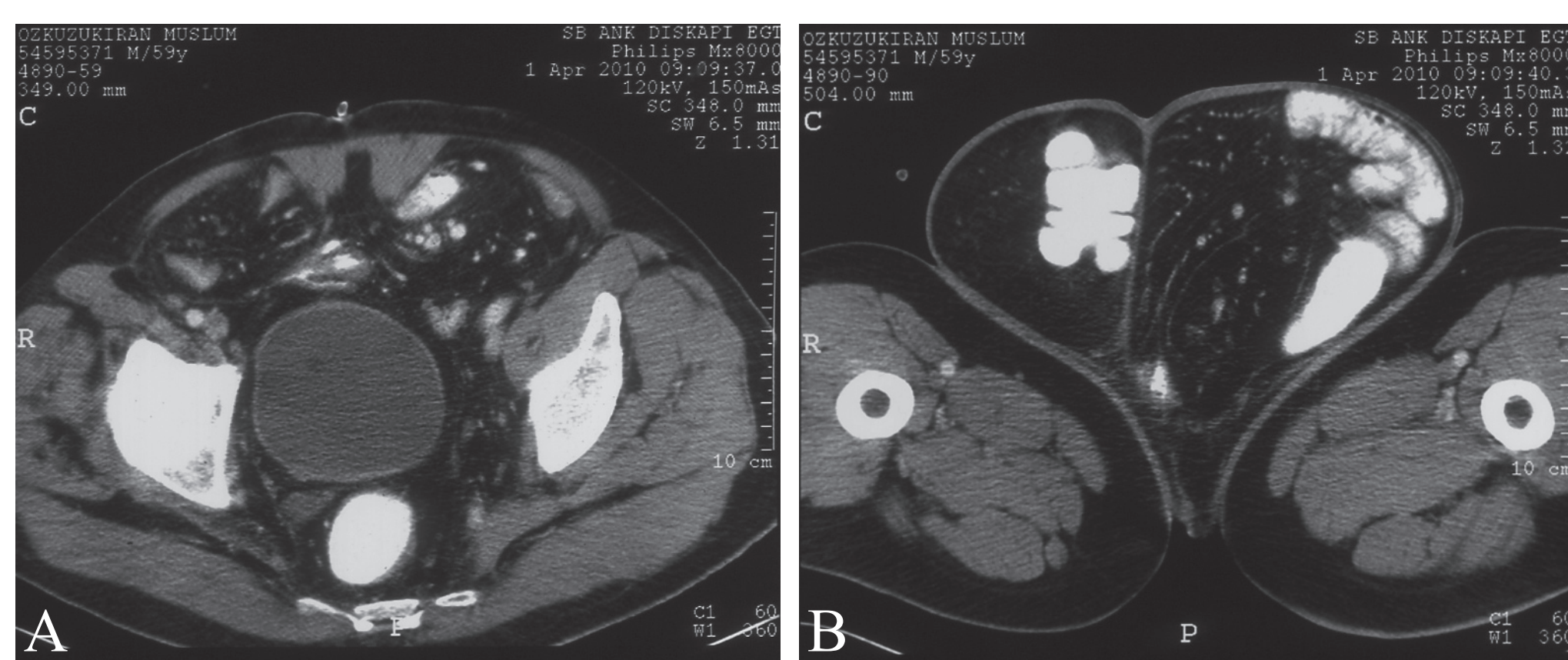


Figure 2: CT features of the hernia. A: Hernia sac is as large as abdominal cavity. B: Very large scrotal hernia sacs containing intestinal segments.

Therefore, it was decided to set a gradual pneumoperitoneum before the repairs. However, the patient could not tolerate this procedure and developed respiratory distress and cyanosis. Then, he was scheduled for an intraabdominal mesh repair and component separation to enhance intraabdominal volume.

Standard polypropylene mesh sheets were used for inguinal repairs via intra-abdominal approach, and a large sheet of partly absorbable lightweight composite mesh was laid on the abdominal wall to cover separated areas (Figure 3). Reduction scrotoplasty was employed as the latest stage of the surgery (Figure 4&5).

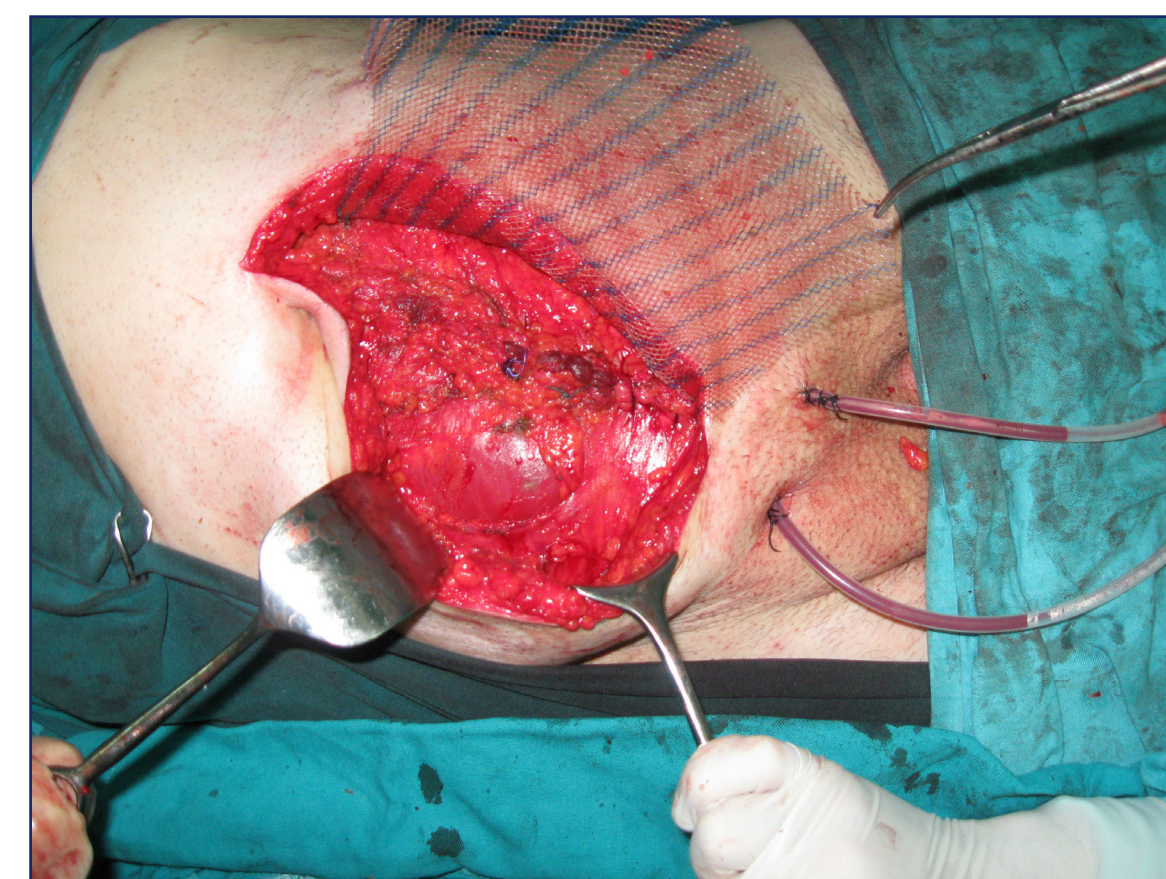


Figure 3: A lightweight composite mesh is used onlay after separation of the abdominal wall layers.

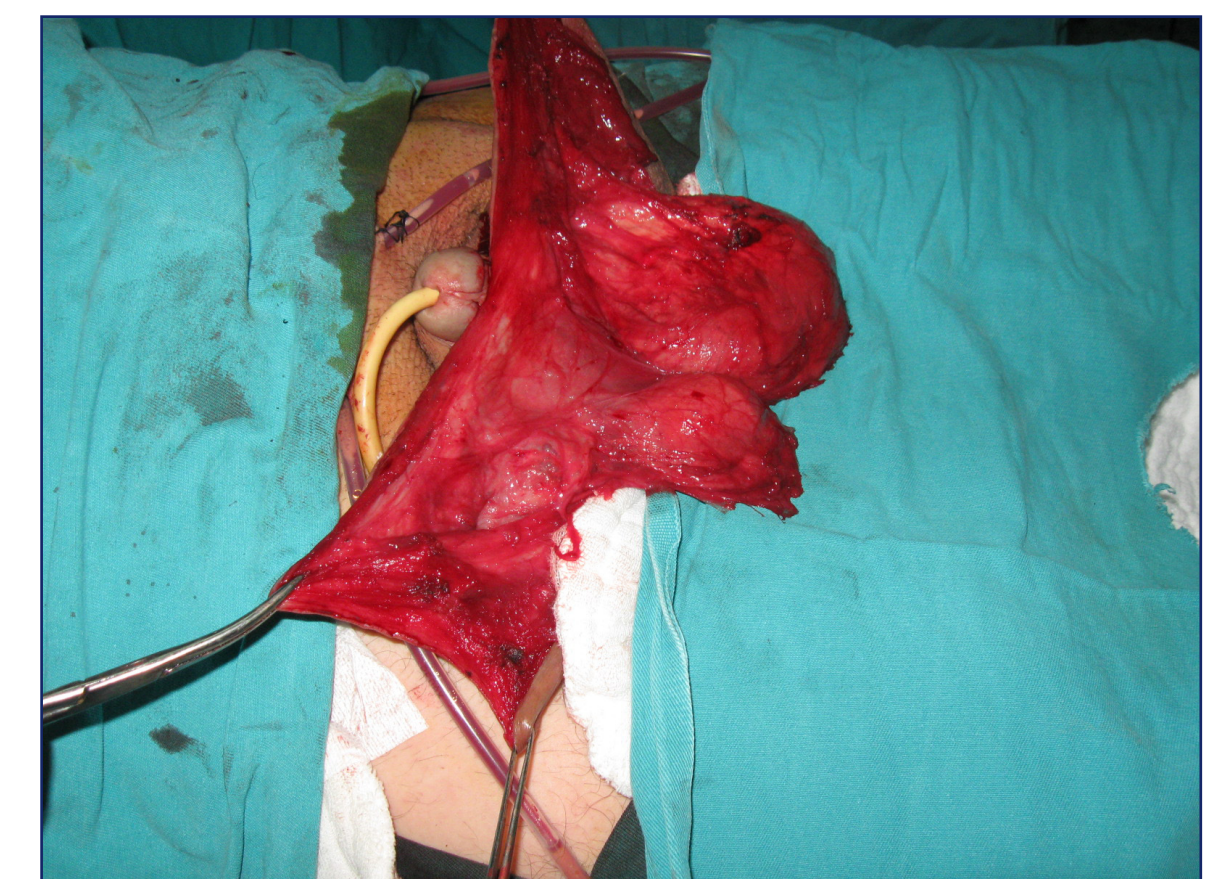


Figure 4: Scrotum is opened wide before reduction scrotoplasty



Figure 5: Surgery completed

The patient stayed in the ICU for 2 days and serum CRP level, intraabdominal pressure (IAP) and blood gas analysis were followed closely. The patient did not need mechanical ventilation. Serum CRP increased to 100 and 125 on 5th and 7th days. It decreased to 21 on day 18th. IAP was 21 cm water right after the operation. It was 14 at postoperative 6th hour and 16 at 12th h. IAP decreased to 12 cm water at 48th h. No respiratory acidosis was recorded. However he needed intermittent nasal oxygen supply. pO<sub>2</sub> was 66.9 on day-3. It reached to normal range at day-5. A spontaneous serous drainage was met after 7th day. It responded well to conservative approach with twice daily dressings. The patient was discharged on postoperative 19th day. He is doing well after 12 weeks (Figure 6)

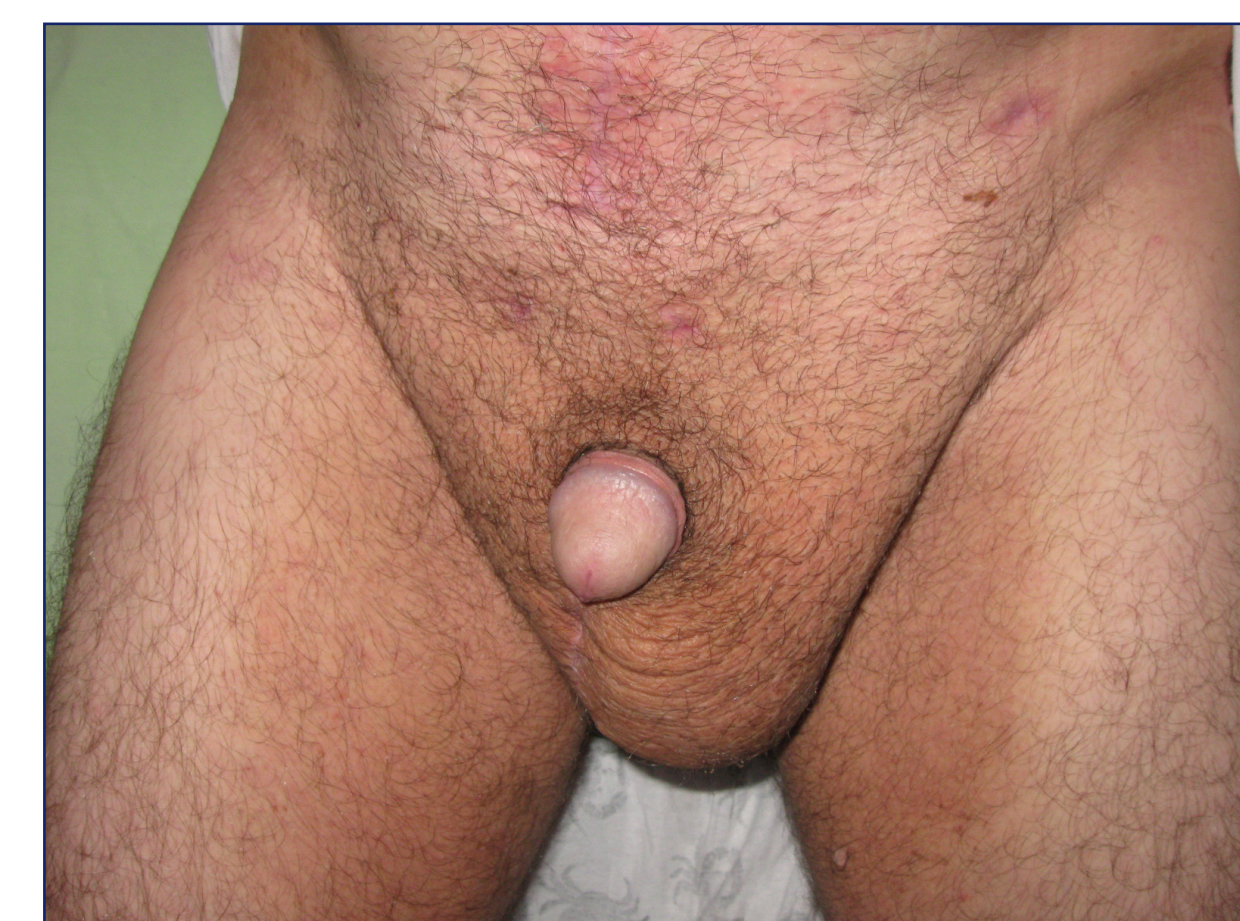


Figure 6: Patient at postoperative 12th week.

## Comment

Component separation technique may be a good solution for giant inguino-scrotal hernias by facilitating the repair and avoiding the intraabdominal compartment syndrome.