Medical Memoranda

Strangulated Cloquet's Hernia

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Since its original description by Callisen (1777) and Cloquet (1817) pectineal hernia has remained something of a surgical Cinderella. Cloquet's pectineal hernia, in which the sac enters the thigh through the femoral ring and then passes down within the substance of the pectineus muscle, has been described by Aird (1957) as one of the rarest of several rare varieties of femoral hernia. In their monumental work on hernia Nyhus and Harkins (1964) say that "although the paucity of these hernias subsequently reported in the world literature would make us doubt their actual occurrence, the names associated with their description do not allow for ready rejection." Sporadic reports appeared in the Continental literature during the nineteenth and early twentieth centuries, and in 1910 Fasano collected and reviewed 16 cases from the literature. In 1945 Badolle reported a fatal case of strangulation, and in 1948 Freeman presented to the Royal Society of Medicine a case in which Cloquet's hernia was reducible and controllable with a truss.

The present case is unusual in that it followed the repair of a groin hernia many years previously. It was diagnosed at operation and clearly demonstrated certain anatomical features.

CASE HISTORY

A single woman aged 81 was admitted to the Royal Infirmary, Sheffield, as an emergency with a fortnight's history of episodic upper abdominal pain and vomiting. The frequency and severity of the pain had increased for 48 hours, though between spasms she was free of symptoms. Her bowels had been open normally until the day of admission.

She had been known to suffer from myxoedema for 10 years, and was taking L-thyroxine sodium 0.1 mg. daily, but her mental processes and memory were much impaired. She said she had had attacks similar to the present one occasionally for many years, and at one time had been on a fat-free diet.

As a young woman she had had a hernia repaired in the right groin, and more recently had worn a truss in the right groin.

On examination she was obese and mentally retarded, with the typical appearance of a patient with myxoedema. The temperature was 97° F. (36° C.) and the pulse 66/min. Apart from the features of myxoedema, general examination revealed nothing abnormal.

Abdominal examination showed a scar in the right groin suggesting a previous femoral herniorrhaphy. No other abnormality was found in either groin. There was a little tenderness generally in the abdomen but no guarding or rebound tenderness, and the bowel sounds were normal. Nothing abnormal was found on rectal examination. Straight radiographs of the abdomen showed no abnormality.

She was observed for 24 hours, and, as after this time her spasmodic pain and vomiting were continuing, laparotomy was decided upon for a tentative diagnosis of incomplete intestinal obstruction.

At operation a right paramedian incision was made. There was obstruction of the ileum, and on tracing the small bowel downwards

a loop was found to leave the pelvis and enter the thigh through the right femoral ring. The right groin was accordingly opened, and a strangulated hernia containing 2 feet (60 cm.) of terminal ileum was found and reduced. The sac came through the femoral ring and was embedded in the pectineus muscle and therefore was not removed. Both internal inguinal rings and both obturator canals were examined and were normal.

The bowel rapidly became a good colour, and accordingly the femoral canal was repaired from within as in a "high" operation for femoral hernia, and the wounds closed.

Her post-operative course was uneventful, the dose of L-thyroxine sodium was increased, and at follow-up 10 months later she was free of symptoms.

COMMENT

The mechanism of descent of a sac into the substance of the pectineus remains obscure, though it is not surprising that, as in obturator hernia (Wakeley, 1939), considerable lengths of ileum can accumulate in the muscles deeply in the thigh. In Freeman's (1948) case it appeared that the sac lay subcutaneously, superficial to the fascia of pectineus, but in the present case—as in most previously reported cases—the sac was deeply embedded in muscle. Nyhus and Harkins (1964) have suggested that this hernia is usually due to an abnormal insertion of the pectineus muscle. There was no evidence of this in the present case.

The site of the previous incision and the subcutaneous scarring suggested that the previous hernia had been femoral, and it may be that the ensuing fibrosis at the saphenous opening directed the pectineal hernia down the thigh. It is also tempting to think that a femoral hernia repair in which the inguinal ligament had been sewn to the pectineal (Cooper's) ligament may have so distorted the pectineal ligament and fascia as to allow the sac to enter the pectineus muscle. But this is unknown, and it must be an exceedingly rare complication of femoral herniorrhaphy.

In retrospect it seems doubtful if the present patient's hernia could have been controlled by the truss that she said she wore at one time, though Freeman's (1948) patient was able to wear a truss satisfactorily.

The patient was admitted under the care of Mr. Clifford Jones, and it gives me great pleasure to record my thanks to him for his advice.

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