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MEDICAL MEMORANDA

Retroperitoneal Haemorrhage Simulating a Strangulated Inguinal Hernia

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The presence of a painful, irreducible swelling in the groin caused by a retroperitoneal haemorrhage after blunt trauma is reported, which offers an unusual differential diagnosis of a strangulated inguinal hernia.

Case Report

A 53-year-old man presented in the casualty department in March 1972 in the early morning with a painful, tender, irreducible lump in his left groin. He stated that on the previous evening he had fallen from a stool and landed on his back. He got up and shortly afterwards went to bed. Six hours later he woke up with a pain in the left groin. He also complained of pain over his left hip and down the left leg; he was nauseated, and vomited once. A diagnosis of left strangulated inguinal hernia was made, and the patient was referred to the surgical firm on duty for admission.

On examination he did not appear anaemic, shocked, or dehydrated, the pulse rate was 95/min, regular and good volume, and the blood pressure was 130/95 mm Hg. There were superficial bruises in the left flank of the abdomen, and with left-sided tenderness. Bowel sounds were diminished. Examination of the hernial orifices showed a right scrotal hernia, not tender, easily reducible, and with expansile impulse on coughing. On the left side there was a swelling above the midpoint of the inguinal ligament which was tense, tender, irreducible, and without a cough impulse. There was no discolouration of overlying skin, and the testes were normal.

Left hip flexion was limited by 30°; other movements were full. All pulses were present in both legs. X-ray pictures of the abdomen lumbar spine, pelvis, and left hip, and routine tests on the urine showed no abnormality.

A provisional diagnosis of a left strangulated inguinal hernia was made, and at operation one hour after admission the left groin was explored through an inguinal incision. On opening the canal a large haematoma was found deep to the external oblique aponeurosis and superficial to the transverse fascia. The cord appeared normal, and there was no evidence of a direct or indirect sac. The cord was mobilized and retracted; the haematoma was evacuated.

At this stage it was noticed that there was some fresh blood seeping through the deep inguinal ring. The index finger was introduced through the ring into the retroperitoneal space and a further clot was removed. As there was only very slight bleeding further exploration of the retroperitoneal space was not attempted. A Redivac drain was inserted into the deep ring and the canal was closed. A firm dressing was applied to the wound.

Postoperatively there was no evidence of bleeding disease. In-

vestigations were: haemoglobin 13.8 g/100 ml, bleeding time 2 min, clotting time 6 min, prothrombin ratio 1.3, platelet count 159,000/mm³. Liver function tests and an intravenous pyelogram, to exclude a renal injury, showed nothing abnormal.

His postoperative progress was uneventful; there was minimal loss from the Redivac drain, and it was removed on the second day. During the period of recovery he asked to have his right scrotal hernia attended to, and on the eighth day a right inguinal herniorrhaphy was performed. He was discharged from hospital 15 days after admission.

Comment

The common conditions which may simulate a strangulated inguinal hernia are: inguinal lymphadenitis, torsion of undescended testis, encysted hydrocele of the cord, lipomas, a tuberculous psoas abscess pointing above the inguinal ligament, pus in the inguinal hernial sac as a result of general peritonitis (Cronin and Ellis, 1959), and a dermoid cyst of the inguinal canal (Brightmore, 1971).

Handmaker and Mehn (1969) reported a case of haemorrhage into the spermatic cord and testicle simulating an incarcerated inguinal hernia. The patient presented on the sixth day after the start of anticoagulant therapy, with a tender irreducible swelling in the left inguinal canal and scrotum, and with signs of a small intestinal obstruction.

Nick, Zollinger, and Pace (1967) reviewed 65 cases of retroperitoneal haemorrhage secondary to blunt trauma. The causes in their series were renal injuries, fracture of the pelvis and transverse processes, rupture of the bladder, traumatic pancreatitis (4 cases), ruptured aorta (1 case), duodenal injury (1 case), trauma to the adrenal gland (1 case), with eight cases of unknown cause.

In another review of 75 cases by Allen, Eastman, Halter, and Conolly (1969) some causes were renal injuries (17 cases), pancreatic injury (16 cases), bladder laceration (10 cases), pelvic injury (7 cases), and vena cava rupture (4 cases). There were no cases of retroperitoneal rupture of the duodenum and no instances of aortic injury.

In neither series, however, was an extension of retroperitoneal haematoma into the inguinal canal reported.

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