Hernia uteri inguinalis with calcified fibroma of ovary in male: A case report

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Hernia uteri inguinalis (also known as Persistent Mullerian Duct Syndrome) is extremely rare. In this case, a 51 year-old man with the complaint of painful swelling of the right scrotal sac and inguinal region was operated on under the suspicion of having right incarcerated hernia. A standard oblique inguinal incision was performed. The hernial sac contained with uterus, right utricle tube (sliding hernia type) and left ovarian tumour (intraperitoneal part). Hysterectomy with bilateral salpingooophorectomy and herniorrhaphy was made through the inguinal incision. To our knowledge, this is the first case reported of Hernia uteri inguinalis with calcified fibroma of ovary in male.

Keywords: Hernia uteri inguinalis, calcified fibroma of ovary, Persistent Mullerian Duct Syndrome.

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ผลงาน ภัทรภัณฑ์ ฮีร์เนีย เอนเตอร์ อินกูนิลลิส ร่วมกับเนื้องอกรั้งไข่ชนิด calcified fibroma ในผู้ป่วยชาย รายงานผู้ป่วยกรณีศึกษา ขจัดงอกกรณีข้าวสา 2548 ม.ย.; 49(4): 241 – 5

รายงานกรณีศึกษาผู้ป่วย 1 รายมีลักษณะทางเพศภายนอกเป็นชาย อายุ 51 ปี มารังสายบางส่วนอาการปวดและมีก้อนที่ขามนิ้วด้านล่างเป็นได้เลือยชนิดลูดดิน หลังจากทำ การผ่าตัดพบขนาดเล็กในส่วนช่องซีด sliding ประกอบด้วยเนื้อเยื่อและเนื้องอกรั้งไข่ที่ติดต่อกับเนื้อเยื่อ ต้องทำการซ่อมแซมผ่านตัดผนัง ก่อนจะทำการปิดผนังทางตรงบริเวณขามนิ้วข้าง ผลการตรวจเชื้อเนื้องอกรั้งไข่ชี้เป็น calcified fibroma ซึ่งเป็นผู้ป่วยรายแรกที่ได้รับ การผ่าตัดและรายงาน

คำสั่งศูนย์: Hernia uteri inguinalis, เนื้องอกรั้งไข่ชนิด calcified fibroma, Persistent Mullerain Duct syndrome
**Case Report**

A 51 year-old man was referred to the emergency room complaining of painful swelling of the right scrotal sac and the inguinal region 2 days prior to admit. He was classified as American Society of Anesthesiologist I. Past medical history was no contributory; he had no history or evidence of trauma or infertility.

On physical examination, his vital signs were stable. The abdomen was soft and not tender. There was an obvious painful swelling of the right scrotal sac and the inguinal region and normally male secondary sex characteristics. But the right scrotum was not palpable. He was resuscitated with intravenous fluids being taken to the operating room. Since the preoperative diagnosis was right incarcerated hernia, the patient was given prophylactic antibiotics.

After standard oblique inguinal incision was performed, the hernial sac which was found to contain an immature uterus and right uterine tube, Atrophic testis,(sliding hernia type), The uterus was measuring 3.5x3x2 cm³. Its endometrium was 0.2 cm. Thick ; myometrium 1 cm; the attached ovary 2x1x1 cm³. Left uterine tube with 6x3.5x3 cm³. ovarian tumor (intraperitoneal part) diameter, The uteros was excised and bilateral salpingooopherectomy and hemiorrhaphy were made through the inguinal incision.

**Gross pathology and intraoperative part as figure**
The picture shows male secondary sex characteristic and hernia uteri inguinalis with calcified mass of left ovary with testicular atrophy.

Postoperatively he made unevenful recovery and was discharged 3 days later. During his revisit to the Out-patient Department one month later, he was found healthy.

**Surgical pathology report:**

Microscopic finding: section of ovarain nodule composed of atrophic hyaranizes semiferous tubules with clusters of leydig’s cells. Section of structure resembling fallopian tube show epididymis with dilated ducts.

Sections of separated mass composed totally of hyalinized collagenised tissue with extensive calcification. No ovarian tissue seen.

**Diagnosis:** Uterus with one adnexa
- weakly proliferative endometrium.
- unremarkable myometrium.
- attached adnexae composed of atrophic testis with dilated epididymis.

Separated mass
- totally calcified mass, probably calcified fibroma of ovary.

**Discussion**

Hernia uteri inguinalis (also known as Persistent Mullerian Duct Syndrome (PMDS)) which cause by impaired action of Mullerian Inhibiting Substance (MIS) in regreasithy the Mullerian duct. The Mullerian duct structures include the uterus, the fallopain tubes and the vagina. An etiology of this syndrome may be genetically inherited either by autosomal recessive genes with sex limitation or X-linked recessive mutation. Preoperative diagnosis of hernia uteri inguinalis is difficult. Various organs have been found in indirect inguinal sac, but the presence of uterus in inguinal hernia in male has only rarely been first described by Nilson 1939. He described three main types of hernia uteri inguinalis, namely:

Type I the uterus and adnexa of both sides are present in the hernia.

Type II the uterus and adnexa on one side are contained in the hernia and the adnexa on the other side remain in the peritoneal cavity.

Type III a unicorneate uterus, or one horn of a bicorneate uterus, with its corresponding adnexa are contained in the hernia.

The possibility of this type of intersex abnormality is not normally considered until leporotomy or repair of a hernia reveals the abnormality. Nilson, however, suggested that it should be possible to diagnose hernia uteri inguinalis preoperatively by bimanual examination. However, the rare condition is not known to the surgeon and it was not kept in mind then that diagnosis might be possible. The treatment is controversial with most clinicians recommending excising the persistent Mullerian structures but due to close location with the vas deferens and Mullerian structures, it is easy to injure the vas deferens. Some clinician suggest leaving the persistent Mullerian structures intact because malignancy has not been reported and no such problems exist, in order to avoid malignancy orchiectomy should be performed in adults in case of undescended testis.
Conclusion

A case of Type II hernia uteri inguinalis (Nilson 1939) that occurred in a phenotypically normal 51 year-old male but, to our knowledge, this is the first case report of hernia uteri inguinalis with calcified fibroma of ovary in male.

References


