



Time is the best healer and revealer: Doctors we just diagnose— Spontaneous resolution of large inguino-scrotal hernia with mesenteric volvulus

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Abstract

Background: Incarcerated inguino-scrotal hernias associated with mesenteric volvulus typically represent a surgical emergency due to the imminent risk of bowel ischemia and necrosis. While the standard of care in 2026 dictates immediate surgical exploration for non-reducible hernias with signs of strangulation, rare "spontaneous" reductions can occur, revealing the dynamic nature of bowel herniation.

Key words: Abdominal pain; Pneumotosis intestinalis; Right inguino-scrotal hernia

1. Case Presentation

55 years old male patient came to ER with history of abdominal pain since 2 days and a large right scrotal swelling. Plain CT scan of abdomen and pelvis was done which showed Large abdominal wall defect (3.5 x 2.8 x 3.7 cm) in right inguinal region through which redundant sigmoid colon and distal ileal loops with their mesentery were seen to herniate into right scrotal sac. Free fluid noted within right scrotal sac with edema of bowel walls within. No significant bowel dilatation noted in the abdomen or right scrotal sac.

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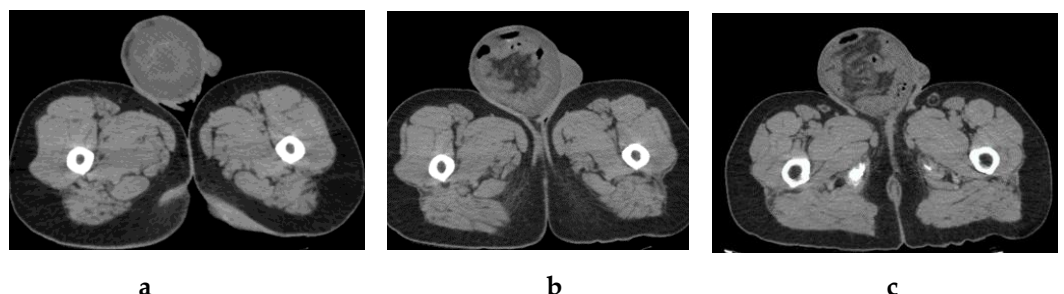


Fig (1) (a,b&c): Plain CT axial images of right inguinal hernia with free fluid in right scrotal Sac

Whirlpooling of mesenteric blood vessels noted in right lower quadrant of abdomen, proximal to right inguinal orifice – suggest twisted mesentery. Diffuse haziness and edema of mesentery noted in abdomen with vascular engorgement and minimal free fluid in abdomen and pelvis.



Fig (2) (a,b&c): Plain CT axial images showing Crowding and whirlpooling of vessels at right inguinal orifice, mesenteric vascular congestion, edema and panniculitis.

- Significant free fluid was noted in right scrotal sac.
- No significant bowel wall thickening or dilatation seen.
- No evidence of pneumatosis intestinalis or pneumoperitoneum seen.

Above features suggest large right inguino-scrotal hernia with mesenteric volvulus with no definite signs of bowel obstruction

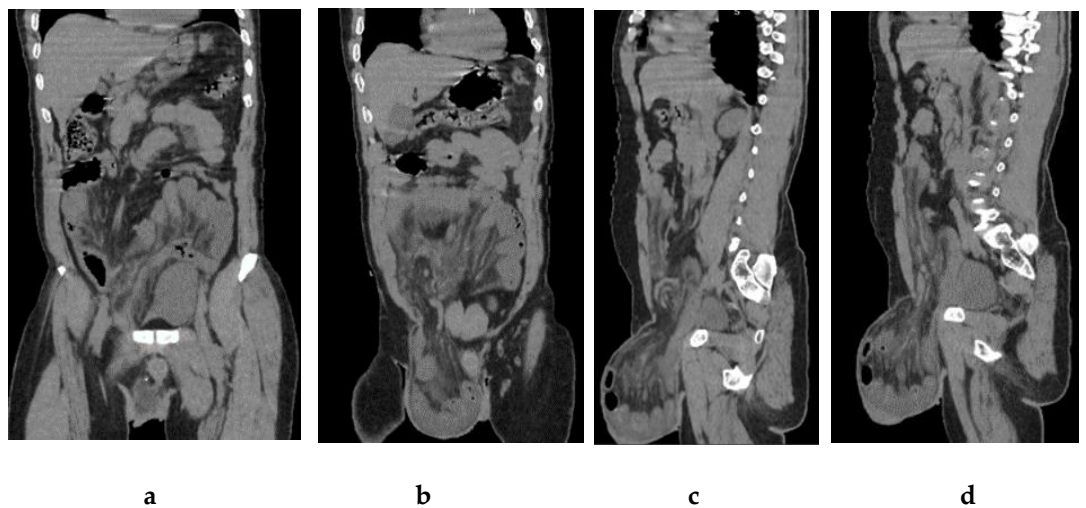
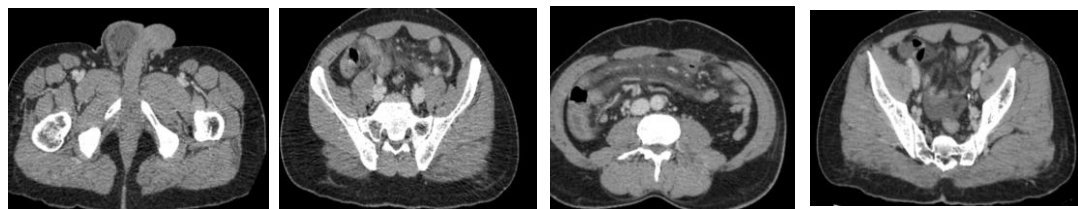


Fig (3): (a,b,c & d) : Coronal and sagittal reconstructed images of right inguino-scrotal hernia with mesenteric edema and vascular whirlpool proximal to inguinal orifice.

Contrast enhanced multislice CT scan of abdomen and pelvis was done after three hours of plain CT study which revealed :

Surprisingly there was absence of a visible hernia bulge in the right inguino-scrotal region. Residual fluid collection noted in right inguino-scrotal region, indicating the original hernia tract and the remaining empty sac.



a

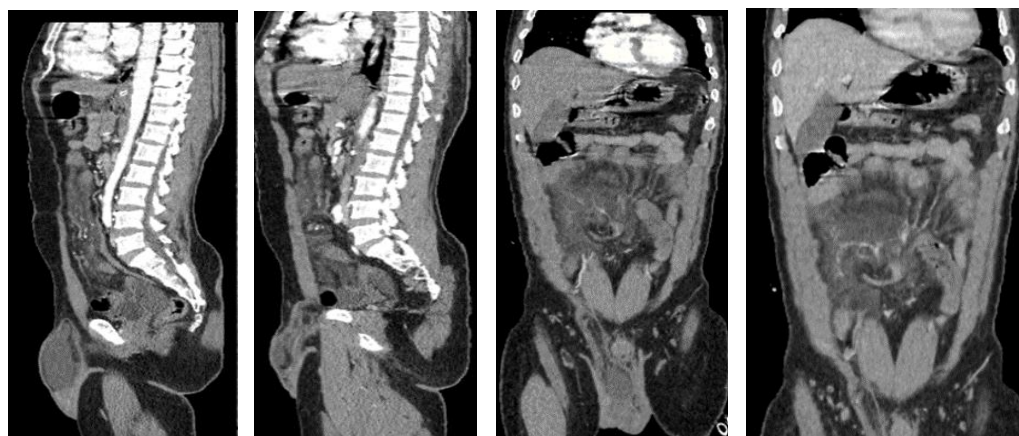
b

c

d

Fig (4): (a,b,c &d): CECT axial images after 3 hours during venous phase showing right scrotal sac and inguinal canal with fluid, no hernia, mesenteric and bowel edema.

Diffuse mesenteric edema and venous engorgement noted with few distal ileal loops showing wall thickening, mucosal edema and hypoenhancement on venous phase. Mesenteric arterial branches appeared intact. Minimal free fluid noted in abdomen and pelvis. No signs of mesenteric vascular whirlpooling / closed-loop obstruction noted. No signs of pneumatosis intestinalis or pneumoperitoneum seen. No signs of small bowel obstruction noted on the CECT scan, such as dilated bowel loops and air-fluid levels.



a

b

c

d

Fig. (5): (a,b,c & d) : Coronal and sagittal CECT images in Arterial and Venous phases showing right scrotal sac with fluid, no hernia, intact mesenteric arterial supply and venous congestion of mesentery and small bowel.

2. Diagnosis

Spontaneous resolution of large inguino-scrotal hernia with mesenteric volvulus, residual mesenteric venous congestion and no definite signs of bowel obstruction.

2.1 Differential Diagnosis

- Is it a wrong patient ? No. Patient's identity was reconfirmed by their name, age, sex and ID number.

- Anyone attempted Taxis Maneuver of manual reduction of inguinal hernia, where protruding tissue is gently pushed back into abdomen – No.
- Did oral contrast aid in spontaneous resolution ? By mechanically repositioning the bowel / by stimulating peristalsis as contrast moves through the gut, essentially untwisting a small bowel volvulus and reducing a trapped loop – No since oral contrast was not administered in this patient.
- Is it reduction en masse of an incarcerated hernia? Where inguinal hernia gets reduced into preperitoneal space instead of into peritoneal cavity through inguinal canal. The bowel remains entrapped inside the hernia sac within the preperitoneal space which is a surgical emergency.

Reduction en masse of an inguinal hernia is a rare but potentially morbid cause of intestinal obstruction as the incarcerated inguinal hernia is essentially converted to an internal hernia, a closed-loop obstruction and continuing ischemia with ongoing risk of bowel strangulation and gangrene – No. In this case there is no definite CT signs to suggest reduction en masse.

2.2 Diagnostic laparoscopy

Done to rule out reduction en masse, bowel gangrene and to avoid future recurrence of hernia revealed congested distal ileal walls with no signs of ischaemia or gangrene consistent with CECT findings.

3. Conclusion

Spontaneous resolution of large inguino-scrotal hernia with mesenteric volvulus is a rare phenomenon – The reason why this case report is presented. Though time is the best healer, as doctors we know the value of time, any delay in diagnosis or treatment can worsen acute abdominal emergencies related to bowel leading to bowel gangrene, perforation and life threatening peritonitis. In this case the patient was fortunate enough to have transient venous compromise rather than an arterial occlusion, that's why the patient escaped from all life threatening complications related to bowel ischemia which we could expect even after the spontaneous resolution of hernia. Remember time is the best healer and revealer only in such rare cases of spontaneous resolution; but timely diagnosis and management is really crucial and lifesaving in all abdominal emergencies !!

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