

Letters to the Editor

Strangulated femoral hernia: the clinical trap

Sir,

We read with interest the paper by Heys and Brittenden on 'Strangulated femoral hernia: the persisting clinical trap'.¹ We have had 4 similar cases in the last year.

A 57 year old woman with a known history of inflammatory bowel disease presented to the medical ward with abdominal pain and vomiting. Examination and abdominal X-rays were consistent with small bowel obstruction. However, the findings were attributed to an exacerbation of the patient's Crohn's disease, which had been clinically dormant for 6 years. Two days later, a surgical opinion revealed an irreducible and tender left femoral hernia. At operation, a small segment of necrotic small bowel was resected and there was no evidence of active Crohn's disease. The hospital stay was 19 days and the patient made a good recovery.

An obese 79 year old woman was referred to the duty surgical team with a 4-day history of abdominal pain and vomiting. She was taking ibuprofen for osteoarthritis, and her general practitioner treated her for gastritis/peptic ulceration. On admission she had clinical and radiological evidence of small bowel obstruction with an irreducible right femoral hernia. Surgery was carried out urgently, and a segment of necrotic ileum was resected. Her recovery was complicated by chest and wound infections, and an ileus which lasted 7 days. The hospital stay was 24 days.

An 84 year old woman was referred from the geriatric department with a 5-day history of a tender swelling in the right groin. A diagnosis of lymphadenopathy was made and the patient investigated accordingly. However, worsening vomiting and abdominal pain precipitated referral to the surgeons who diagnosed a strangulated femoral hernia. Urgent surgery was undertaken with resection of a small bowel segment. The patient's recovery was complicated by chest infection and wound infection and breakdown. The hospital stay was 35 days.

A 92 year old woman was admitted with abdominal pain and vomiting. She had received laxatives for constipation several days prior to admission. On examination she was confused, dehydrated and had clinical and radiological evidence of small bowel obstruction with an irreducible right femoral hernia. At laparotomy, an ischaemic segment of small bowel was resected. The patient had a wound infection and was discharged home on the 36th postoperative day.

The delay in establishing the diagnosis in these patients resulted in small bowel resection, increased morbidity and long hospital stay. The importance of examining hernial orifices as part of abdominal examination cannot be over-emphasized. Furthermore, a swelling in the groin should be considered as an irreducible hernia until proven otherwise, especially if accompanied by abdominal symptoms. The diagnosis of intestinal obstruction must be considered in the presence of abdominal pain and

vomiting, and the persistence/worsening of these symptoms requires early surgical intervention.

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Reference

1. Heys, S.D. & Brittenden, J. Strangulated femoral hernia: the persisting clinical trap. *Postgrad Med J* 1991, 67: 57–59.

Fenfluramine – induced irreversible pulmonary hypertension

Sir,

Fenfluramine hydrochloride is a sympathomimetic agent used as an anorectic in the treatment of obesity.¹ Fenfluramine has been implicated in drug-induced pulmonary hypertension in three female patients.^{2,3} In all cases, symptoms disappeared after discontinuation of fenfluramine. We report a possible case of fenfluramine – induced pulmonary hypertension in a young woman; in this case, however, the pulmonary hypertension appeared to be irreversible.

A 26 year old woman presented in December 1987 with a 3-month history of dyspnoea, orthopnoea and ankle swelling. In 1982, she had started using fenfluramine for weight reduction; her weight at that time had been 75 kg and height 155 cm. In the subsequent 5 years, she had used the drug for several months intermittently (60 mg daily) and for 10 months continuously before admission (60–120 mg daily). On admission she weighed 107 kg. Cardiovascular examination showed a blood pressure of 110/90 mmHg. On auscultation there was an atrial gallop rhythm; the pulmonary component of the second heart sound was accentuated and there was a palpable systolic pulsation in the second left intercostal space. A systolic murmur was heard along the left sternal border and there was also a holosystolic murmur of tricuspid regurgitation. The electrocardiogram showed sinus rhythm, right ventricular hypertrophy and T wave inversion and the chest radiograph slight cardiac enlargement with prominent main pulmonary arteries. Arterial blood gases showed a P_{aO_2} of 58.7 mmHg and a P_{aCO_2} of 43.3 mmHg, pH 7.42 and saturation 87.9%. A ventilation/perfusion lung scan was normal. Echocardiogram (M-mode, 2D and Doppler) showed significant right atrial and right ventricular dilatation with overload of the right ventricle.