

Hidden in the Groin: Incidental Discovery of a Large Inguinoscrotal Bladder Hernia on Cross-Sectional Imaging

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Abstract

Inguinal bladder hernia is an uncommon condition, accounting for only 1 - 4% of all inguinal hernias, and is frequently painless, slow-growing, and underreported by patients. We report the case of a 58-year-old man with no relevant past medical history who presented with acute epigastric pain suggestive of pancreatitis. Contrast-enhanced CT confirmed mild acute pancreatitis and incidentally established the diagnosis of a large right inguinoscrotal bladder hernia, corresponding to a longstanding, painless swelling that the patient had never reported. This case illustrates the value of systematic review of the entire imaging volume and highlights how even sizeable bladder hernias may go clinically unrecognized until incidentally confirmed on imaging performed for an unrelated condition.

Keywords: *Inguinal Bladder Hernia; Hydrocele; Incidental Finding; Computed Tomography; Pancreatitis; Scrotal Mass*

Introduction

Inguinal herniation of the urinary bladder is a rare condition, first described by Levine in 1951, occurring in approximately 1 - 4% of inguinal hernias and reaching up to 10% in obese men over 50 years of age [1]. Risk factors include advanced age, male sex, obesity, weak pelvic musculature, and chronic urinary outflow obstruction [1,2]. Several cases of inguinoscrotal bladder herniation, sometimes termed scrotal cystocele, have been reported in the literature, ranging from uncomplicated presentations [3,4] to complicated, irreducible forms [5]. Because the condition is frequently painless and slow-growing, it is often underreported by patients despite being clinically detectable, and fewer than 10% of cases are diagnosed preoperatively, with the majority identified incidentally on imaging or discovered intraoperatively [1,2]. When clinically apparent, it is frequently mistaken for a hydrocele or a simple inguinal hernia, which can expose the patient to the risk of inadvertent bladder injury during surgical repair if not recognized beforehand [6].

Case Presentation

A 58-year-old man with no relevant past medical history presented to the emergency department with acute epigastric pain radiating to the back, associated with nausea and vomiting. Laboratory investigations revealed an elevated serum lipase, raising clinical suspicion of acute pancreatitis.

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On examination, a soft, non-tender right inguinoscrotal swelling was noted, which the patient had not previously reported or sought attention for. He denied any associated pain, urinary symptoms, or recent change in size. Given the acute abdominal presentation, clinical attention was primarily directed toward the pancreatic pathology, and the swelling was not further investigated at that time.

A contrast-enhanced CT of the abdomen and pelvis was performed to confirm the diagnosis and assess disease severity. Imaging demonstrated findings consistent with mild acute pancreatitis, with peripancreatic fat stranding and no evidence of necrosis or local complications. In addition, the lower cuts of the study revealed a large herniation of the urinary bladder through the right inguinal canal into the scrotal sac, corresponding to the previously noted swelling. Careful review of the sequential axial images demonstrated direct continuity between the herniated structure and the bladder dome (Figure 1), with contrast opacification of the herniated segment following intravenous contrast administration (Figure 2), confirming its vesical origin. No associated hydronephrosis, bladder wall thickening, or signs of incarceration were identified.

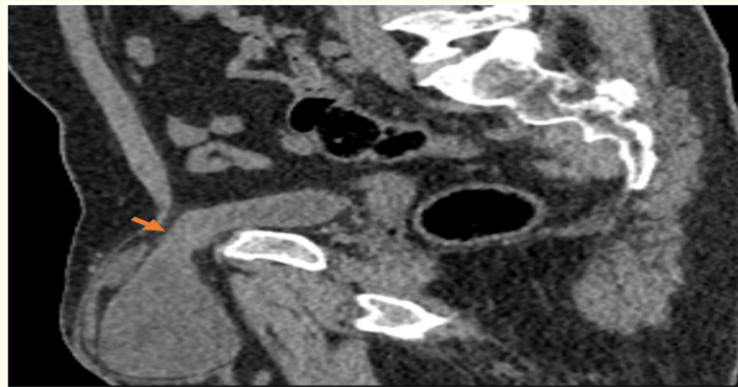


Figure 1: Contrast-enhanced sagittal CT reconstruction demonstrating right inguinal bladder herniation through a 15-mm fascial defect (Orange arrow), with protrusion of the urinary bladder into the right inguinal canal.

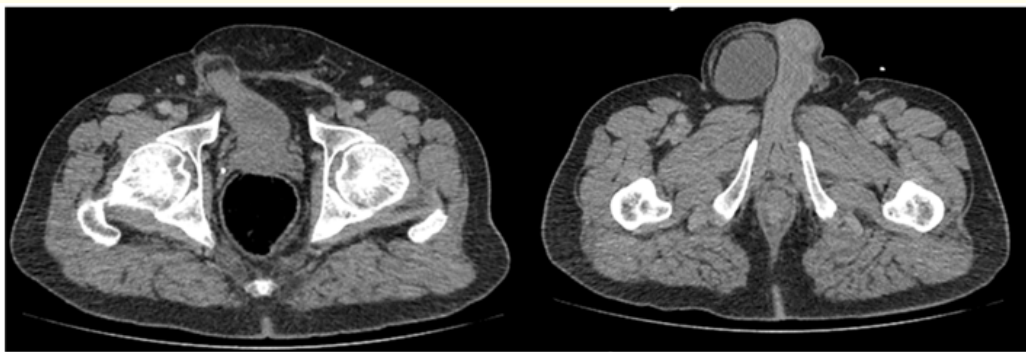


Figure 2: Axial contrast-enhanced CT of the abdomen and pelvis: herniation of the right lateral bladder wall through the right deep inguinal ring, consistent with a right inguinal bladder hernia. No evidence of associated wall complication.

The patient was managed conservatively for his pancreatitis with supportive care, and a urology consultation was requested for further evaluation and elective management of the bladder hernia.

Discussion

Inguinal bladder hernia most commonly affects elderly, obese men, in whom advanced age, chronic urinary outflow obstruction, weak pelvic musculature, and obesity are recognized predisposing factors [1]. Fewer than 10% of cases are diagnosed preoperatively, with the large majority identified incidentally on imaging or discovered intraoperatively [1,2].

This case also illustrates a recognized feature of inguinoscrotal bladder hernias: even when clinically apparent, such masses are frequently painless, slow-growing, and go unreported by patients, delaying diagnosis until imaging performed for an unrelated reason incidentally establishes the diagnosis [1]. This diagnostic ambiguity carries real clinical consequences: a bladder-containing inguinoscrotal hernia was reported to have been previously and incorrectly diagnosed as a hydrocele by two separate physicians, with the true diagnosis only established after the patient developed complications requiring emergency surgery, ultimately followed by septic shock and acute respiratory distress syndrome [6].

Cross-sectional imaging, particularly contrast-enhanced CT, plays a central role in establishing the diagnosis, as it reliably demonstrates continuity between the herniated structure and the bladder, along with contrast opacification of the herniated segment — a key feature distinguishing bladder herniation from a hydrocele or other scrotal fluid collections [7]. In the case reported here, the diagnosis was established incidentally during imaging performed for an unrelated acute abdominal condition, underscoring the importance of a systematic review of the lower abdominal and pelvic cuts on any abdominal CT, even when the clinical indication lies elsewhere, and even when a groin abnormality was already clinically present but not the initial focus of concern.

Conclusion

This case illustrates the incidental diagnosis, on CT performed for suspected pancreatitis, of a large right inguinoscrotal bladder hernia that had remained clinically unreported by the patient despite being palpable on examination. It reinforces the importance of a thorough, systematic review of pelvic structures on abdominal imaging performed for unrelated indications, and highlights cross-sectional imaging as a reliable, noninvasive means of correctly identifying bladder herniation and distinguishing it from a hydrocele — a distinction with direct implications for safe surgical planning.

Conflict of Interest

The authors declare no conflicts of interest.

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None declared.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying imaging.

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