A right sided femoral hernia causing small bowel obstruction in a 55-year-old female is presented. She had a small swelling in the right inguinal region for 1 year, which gradually increased in size. The patient also complained of abdominal distension and vomiting. Abdominal x-rays were suggestive of a small bowel obstruction. Ultrasound confirmed a femoral hernia with non-reducible small bowel and omentum. CECT abdomen showed dilatation of the small bowel loop with air fluid levels within it. Emergency exploration and pre-peritoneal meshplasty were performed. The post-operative period was uneventful, and the patient was discharged on the 4th post-operative day without any complications.

**Key words:** Femoral Hernia, Small Bowel Obstruction, Emergency laparotomy, Pre Peritoneal Meshplasty.
DISCUSSION
A femoral hernia is an extension of a viscus in the course of the femoral canal and exit via the saphenous opening due to a defect in the femoral ring. It is the third commonest hernia and twenty percent happening in women versus 5% in men. This hernia is more common on the right side of multi-parous old women. The femoral ring is bordered anteriorly by the inguinal ligament, posteriorly by the iliopectineal ligament, medially by the lacunar ligament, and laterally by the femoral vessels. The narrow femoral canal and rigid femoral ring are the main cause of bowel incarceration, strangulation and bowel resection which has been shown to have increased mortality and morbidity.

The etiology is a controversial topic due to lack of data in condition of congenital versus acquired hypothesis. The acquired theory is widely accepted with a general clarification of increased intra-abdominal pressure from chronic bronchitis and constipation leading to stretching of the femoral ring from a dilated femoral vein. Clinical manifestation possibly the sensation of a bulge in the groin. Colicky abdominal pain and vomiting may persever e due to incarceration and obstruction or strangulation of small bowel. On examination, the hernia can be recognized below and lateral to the pubic tubercle; it may be generally irreducible and may be tender. A femoral hernia needs to be distinguished clinically from other groin lump for example inguinal hernia, saphenarvaricocel, groin lymphadenopathy, lipoma, femoral artery aneurysm, and psoas muscle abscess. Generally diagnosis is clinically; but, imaging techniques such as ultrasound, CT, MRI or diagnostic laparoscopy may be useful. The protruded viscous is strangulated and undergoes a tissue necrosis in the femoral hernias more than other types of hernia. When diagnosed, femoral hernias should be electively repaired as soon as possible. The golden standard operative management to repair the defect are using either the McEvedy operation or totally extraperitoneal approach (TAPP). Femoral hernia is a rare cause of gastrointestinal obstruction and is at high risk of strangulation due to the narrow femoral canal and femoral ring.

CONCLUSION
Obstructed femoral hernia of the small bowel is rare and the general surgeon should be familiar with femoral hernia as a bowel obstruction source.

REFERENCES