A 69-year-old man with chronic kidney disease, baseline creatinine 1.3-1.5 mg/dL, and an indwelling urinary catheter was admitted to inpatient medicine for evaluation of right scrotal pain, penile pain, decreased urine output, and hematuria 2 weeks after undergoing robotic bilateral inguinoscrotal hernia repair. Computed tomographic abdomen and pelvic imaging on admission demonstrated a large right direct inguinal hernia extending into the hemiscrotum containing cecum, small bowel, distal ureters, and distended urinary bladder with bilateral hydroureteronephrosis (Figures 1-3). Laboratory values demonstrated an acute kidney injury with serum creatinine of 2.58 mg/dL.

An interventional radiologist fluoroscopically repositioned the urinary catheter, which resolved the patient’s pain. The catheter was initially situated at the base of the bladder with tight narrowing of the bladder as it extended into the inguinal canal. The catheter was advanced into the distended herniated portion, decompressing the bladder within the right inguinal hernia. The patient also underwent treatment for a Pseudomonas sp. urinary tract infection. At discharge, his creatinine was 1.3 mg/dL. After resolution of his infection, open right inguinal hernia repair was performed for definitive treatment. Massive inguinoscrotal bladder hernias are rare with risk factors...
including obesity, advanced age, decreased bladder tone, and abdominal or pelvic wall weakness. They require emergency management for drainage until definitive surgical repair can be accomplished.

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