Incarcerated Paraesophageal Hiatal Hernia

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Abstract

The paraesophageal hernia (PHE) affects 5-10% of patients with hiatal hernia, most of which is usually small. The recommendation is to treat the PHE before developing into incarceration or strangulation, which can be devastating if not treated in time. The treatment with successful one case of the PHE incarcerated IV type, on the cholecystectomy postoperative justifies this report.

Keywords: Hiatal hernia; Paraesophageal hernia; Complications

Introduction

The paraesophageal hernia (PEH) affects 5-10% of patients with hiatal hernia, most of which is usually small. Risk factors for its occurrence are: advanced age, smoking, diabetes and collagen vascular diseases. The recommendation is to treat the PHE before developing into incarceration or strangulation, which can be devastating if not treated in time. Mortality can be high if operated in emergency condition, resulting to the co-morbidities in this age group of patients, usually advanced [1,2]. The access can be open or minimally invasive [3,4]. The Treatment of a successful case justifies this report.

Case Presentation

Female patient, 52 years old, with cholelithiasis, was admitted to the service on 17/11/15 to undergo video laparoscopic cholecystectomy, which was converted to open through sub costal right access (Kocher) due the multiple adhesions by previous laparotomy 20 years ago for the treatment of hiatal hernia. Installed prevention of deep vein thrombosis/pulmonary embolism. In the immediate postoperative the patient accepted diet, but reported walking dyspnoea that progressed to sudden in second postoperative day and oxygen saturation 70% in ambient air. Received cardiologic care to exclude coronary arterial disease and a chest X-ray was performed (Figure 1), showing pulmonary congestion, cardiomegaly, pleural effusion in left lung and suggestive of relapsed hiatal hernia. Excluding pulmonary embolism, multislice computed tomography of the chest (Figure 2) confirmed the diagnosis of paraesophageal incarcerated hernia with intrathoracic stomach.

Indicated surgical reintervention through median access on the 3rd postoperative day, were found: 2/3 firmly imprisoned intrathoracic stomach to the greater omentum and den, with transverse colon up to the diaphragmatic crus and adjacent spleen (type IV). Conduct: judicious reduction of the contents into the peritoneal cavity, partial resection of the sac, closure of the diaphragmatic crus (Figure 3) and treatment to the Hernia by Nissen’s technique. Initial throttling signs were observed (red spots).

In the reduction of the content, there was a small splenic laceration, whose bleeding was not contained by conservative measures having been performed ablation of spleen and vaccination for meningococcus, pneumococcus and Haemophilus. The patient was diabetic, carrier of liver steatosis, arterial hypertension and renal lithiasis. Previous surgery: hiatal hernia, hysterectomy and appendectomy. Former smoker. Dyslipidemic. Satisfactory progress with discharge on the 11th postoperative day. Follow-up in the fourth month after the intervention, still no clinical complaints.

Discussion

The paraesophageal hernia (PEH) carries the potential of a mechanical catastrophe in the obstruction and may develop complications such as gastric volvulus, bleeding, gangrene and perforation [1,2]. Symptoms may not be the expression of an already installed complication and only half of the patients have postprandial epigastric pain, high occult or manifest gastrointestinal bleeding, severe dyspnea (case study) and complete obstruction of signs in cases of organoaxial gastric volvulus [2,3]. Others have long-standing symptoms that are relativized and not assigned to...
a paraesophageal hernia. Found radiological evidence of PEH usually attenuated and attributed to respiratory diseases, coronary arterial disease or confused with common hiatal hernia (sliding). Diagnosed, a paraesophageal hernia should be treated, is the current consensus, except in the presence of prohibitive comorbidities of a surgery because morbidity reaches 50% and mortality by 27% if operated on urgency [1,3,4]. Index falls 0.5%-3% when treatment is installed electively. In this particular case, mild dyspnea denouncing the obstruction was the first postoperative manifestation, only suspected with chest X-ray. Initially attributed to coronary artery disease and heart disease because the patient was a carrier of cardiomegaly and hypertension. And it was still a smoker, but also did not show any symptoms related to hiatal hernia preoperatively. The advanced age and co-morbidities prevail, most of which usually feminine. In this case, the patient was still in her sixties. As for complications related to treatment, early include: esophageal lesions, stomach, spleen and left pleura, late esophageal fistula and early recurrence with volvo. The splenic injury in elective repair of paraesophageal hernias can occur in up to 4.5% of cases and this reintervention must be treated. There are recent reports of laparoscopy success in treating these imprisoned hernias (PEH), however, most still prefer open access [1,4-7]. In this case, the discussion would be the initial pneumoperitoneum can precipitate the incarceration of a paraesophageal recurrent and asymptomatic hernia, whose inference seems to be positive. We conclude that patients surgically treated PEH in the past, should have an endoscopic examination performed preoperatively before a new surgery for abdominal disease, although asymptomatic, because in the case of coexistence of PEH, the treatment would be carried out in the same intervention, preventing an immediate complication that was the lesson of this case.

References