



GIANT HIATUS HERNIA PRESENTING AS DYSPHAGIA: A SURGICAL ENTITY OFTEN OVERLOOKED!

General Surgery

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ABSTRACT

Incidence of hiatus hernia increases with age. Patient presents with complaints of obstructive symptoms such as dysphagia, odynophagia, abdominal pain, early satiety GI bleeding or respiratory symptoms. We report a case report of 65 years old female patients presented with complaints of dysphagia for solid food since 1 year. Radiological investigations and upper GI endoscopy was suggestive of giant hiatus hernia. Patient was surgically treated by laparoscopic Nissen fundoplication.

KEYWORDS

Hiatus Hernia, Nissen Fundoplication

INTRODUCTION

A giant hiatus hernia is a hernia that includes at least 30% of the stomach in the thorax, although a uniform definition does not exist; most commonly, a giant hiatus hernia is a type III hernia with a sliding and para-esophageal component [1]. Patients with a hiatus hernia generally present with epigastric pain, history of heartburn, dysphagia, vomiting, and anemia. We present here a case of giant hiatus hernia presenting with dysphagia and Surgical repair was done laparoscopically involving reduction of hernia sac and its contents with antireflux procedure.

Case Presentation

A 65 years old female patient presented to OPD with chief complaints of dysphagia since 1 year and weight loss since last 1 month. Patient was having dysphagia only for solid food. On physical examination, vitals were normal and pallor was observed, correction of anemia was done through blood transfusion as Hb was 6.4 gm/dl. Rest of hematological and biochemical investigations were normal. Barium swallow was performed and it was suggestive of sliding type of hiatus hernia with herniation of proximal stomach into thorax.

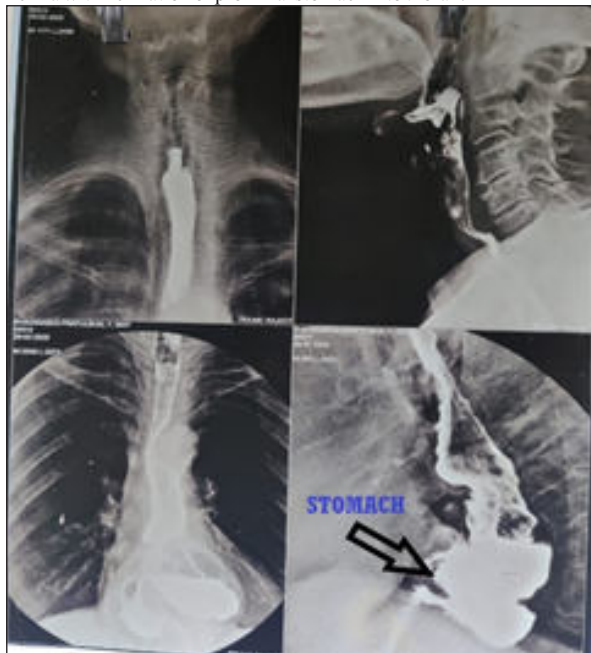


Fig-1 Barium Swallow Image Showing Sliding Type Of Hiatus Hernia-black Arrow

After that Upper GI endoscopy was performed and it was suggestive of sliding variety of giant hiatus hernia and length of sliding hernia was approx 5cm. On CECT (abdomen+pelvis+thorax) there was large

sliding variety of hiatus hernia with gastroesophageal junction approx 50mm above diaphragmatic hiatus.

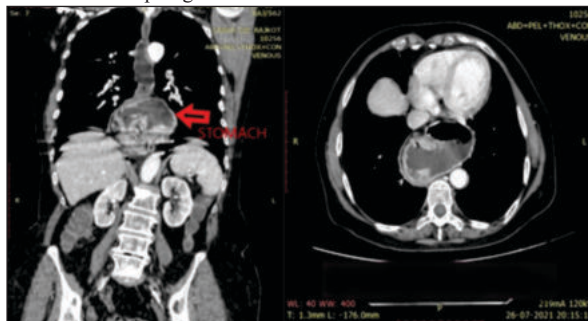


Fig-2 CECT ABD+PEL showing large variety of hiatus hernia-red arrow

Preoperative fitness of patient was done and posted for elective surgery. During laparoscopy surgery large diaphragmatic hiatus was found, reduction of hernia contents was done with tension free closure of hiatus and Nissen fundoplication was performed. Patient was discharged on full diet at POD-8th and at regular follow up after discharge patient was not having any complaints.

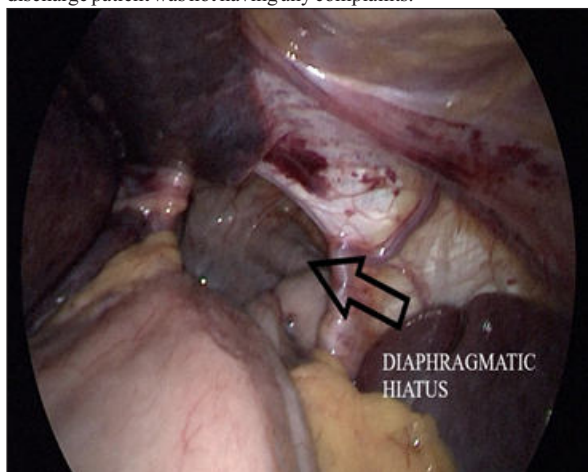


Fig-4 Intraoperative Picture Of Large Diaphragmatic Hiatus-Black Arrow

DISCUSSION

Hiatus hernia is the protrusion of the upper part of the stomach into the thorax through a tear or weakness in the diaphragm. A giant hiatus hernia is a hernia that includes at least 30% of the stomach in the thorax. This may result in gastroesophageal reflux disease (GERD) or laryngopharyngeal reflux (LPR) with symptoms such as, dysphagia,

odynophagia, early satiety, dyspnea, intermittent epigastric and chest pains, and finally heartburn and regurgitation.^[2] Complications may include iron deficiency anemia, volvulus, or bowel obstruction. Four types of esophageal hiatal hernia are identified:^[3]

Type I hernia, also known as a sliding hiatal hernia, occurs when part of the stomach slides up through the hiatal opening in the diaphragm.^[4] Sliding hernias are the most common type and account for 95% of all hiatal hernias.^[5] Type II hernias are rare, it is a true paraesophageal hernia in which there is herniation of fundus of stomach into thorax with GE junction being appropriately located. Type III hernias have elements of both types I and II hernias. Type IV hiatus hernia is associated with a large defect in the phrenoesophageal ligament, allowing other organs, such as colon, spleen, pancreas and small intestine to enter the hernia sac. To diagnose hiatus hernia we perform Barium swallow, UGI Endoscopy, and Esophageal manometry. Giant hiatus hernia is currently treated by a laparoscopic approach in which four key steps are performed: 1) reduction of the hernia contents to the abdominal cavity, 2) complete excision of the hernia sac from the posterior mediastinum, 3) mobilization of the distal esophagus to achieve a minimum of 3cm of intraabdominal esophageal length and 4) an antireflux operation.^[6]

CONCLUSION

Giant hiatal hernias should be considered in the differential diagnosis as a rare intra-abdominal cause of persistent dysphagia. It should be kept in mind that large hiatal hernias can lead to complications and thus interventions need to be done at earliest. Cases with large hiatal hernias should be assessed by physical examination and various imaging modalities.

REFERENCES

1. Mitiek, MO "Giant Hiatal Hernia" *Annl Thor Surg* 2010 Jun;89(6):S2168-73
2. Roman, S., & Kahrilas, P. (2014). The diagnosis and management of hiatus hernia. *BMJ: British Medical Journal*, 349.
3. Kahrilas, P. J., Kim, H. C., & Pandolfino, J. E. (2008). Approaches to the diagnosis and grading of hiatal hernia. *Best practice & research. Clinical gastroenterology*, 22(4), 601–616. <https://doi.org/10.1016/j.bpg.2007.12.007>
4. Kahrilas, P. J., Kim, H. C., & Pandolfino, J. E. (2008). Approaches to the diagnosis and grading of hiatal hernia. *Best practice & research. Clinical gastroenterology*, 22(4), 601–616. <https://doi.org/10.1016/j.bpg.2007.12.007>
5. Kasper, D., Fauci, A., Hauser, S., Longo, D., Jameson, J. & Loscalzo, J. (2015). *Harrison's principles of internal medicine*. New York: McGraw Hill Education.
6. Townsend, Courtney M., R. Daniel Beauchamp, B. Mark Evers, and Kenneth L. Mattox. *Sabiston Textbook of Surgery: The Biological Basis of Modern Surgical Practice*. 20th edition. Philadelphia, PA: Elsevier Saunders, 2017