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ATYPICAL PRESENTATION OF HIATAL HERNIA FOLLOWING ROUX –EN – Y GASTRIC BYPASS BARIATRIC SURGERY

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ABSTRACT

Bariatric surgery alters normal anatomy of alimentary canal. If hiatal hernia occurs after Roux –en –Y bypass surgery it becomes difficult to diagnose as it will not present with typical symptoms. Majority of patients may remain asymptomatic or may present with atypical symptoms like epigastric pain radiating to jaw or back.

In this case a 60-year-old lady who previously underwent gastric bypass surgery for weight loss along with hiatal hernia repair was diagnosed as a case of recurrent hiatal hernia and treated laparoscopically.

INTRODUCTION

Bariatric surgery alters foregut anatomy and hiatal hernia following such procedure may present with difficulty in diagnosis and management. In Roux-en-y gastric bypass(RYGB), the newly formed stomach pouch may migrate intra-thoracically as it loses its attachments to surrounding structures[1].

These patients do not present with typical symptoms of Gastro-oesophageal Reflux Disease(GERD) and may even remain asymptomatic for many years. Patients may present with nonspecific symptoms of Jaw pain, vomiting and inability to eat[2].

There are not many studies in literature about hiatus hernia after RYGB. Here we present a case of a 60 years old lady who previously underwent gastric bypass surgery for weight loss along with hiatal hernia repair was diagnosed as a case of recurrent hiatal hernia and treated laparoscopically.

CASE REPORT

A 60 years old lady underwent laparoscopic RYGB in 2014 for morbid obesity. Her Body Mass Index(BMI) at that time was 41Kg/m^2. Her post-operative recovery was good and she was discharged on day 6. She lost desirable amount of weight over next 5 years and her BMI came down to 32 Kg/m^2.

However, four months back she developed epigastric pain radiating to left shoulder and jaw. Pain was exacerbated by eating and drinking.

She was investigated. CT Scan with oral and intravenous contrast showed a Hiatal hernia with residual stomach pouch in thorax. An upper GI endoscopy was done which revealed normal oesophageal and jejunal mucosa.

Decision was made to procced with laparoscopic repair of the hernia. During surgery it was found that there were dense adhesions around the hiatus, which were meticulously cleared. Oesophagus and residual stomach pouch were mobilised and brought into abdominal cavity (Fig 1). Hiatal defect was closed with interrupted Prolene sutures (Fig 2) and a 32 French bougie was passed intraoperatively to check if closure was not too tight.

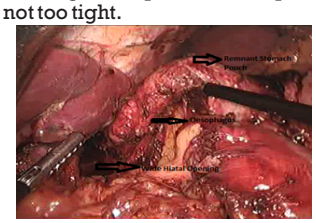

Fig 1: Anatomy after dissection

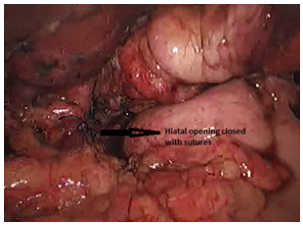

Fig 2: Anatomy after closure of Hiatal defect

Patient''s post-operative recovery was uneventful and she was discharged on third post-operative day. During her follow up, her symptomps have been totally relieved and she is now able to take proper meals.

DISCUSSION

Hiatal hernia post RYGB has not been extensively studied. Its diagnosis is difficult as patient may present with atypical symptoms like pain in left shoulder, mid scapular region and left jaw which may be exacerbated by eating[3]. A high index of suspicion should always be kept in mind while evaluating post RYGB patients with such presentation.

CT Scan with oral contrast and upper GI endoscopy are useful in establishing the diagnosis. Mostly there is complete resolution of symptoms after definitive surgical repair as also seen in the present case[4]. However, surgery itself is challenging in view of altered anatomy and presence of adhesions due to previous procedure. Hiatal closure may require use of mesh if defect is too big[5].

Hiatal hernia post RYGB needs to be further studied and researched to make its diagnosis and management easier.

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