



Strangulated Right Diaphragmatic Hernia: A Diagnostic Trap to Avoid

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Clinical Image

A 78 year old woman with chronic obstructive pulmonary disease (COPD) post tobacco (30 packs annually) and Cardiac Arrhythmia was admitted to our hospital. It was noted a medical history of laparotomy sub costal for cholecystectomy 20 years ago. She present with worsening of respiratory symptoms such as dyspnoea of rest for more than one week. Physical examination showed the patient was afebrile with acute respiratory distress (oxygen saturation at 87%) associated with confusion (Glasgow score: 10) and a high blood pressure situation (200/100 mm Hg) accompanied by tachycardia (heart rate approximately 125 beats per minute) and abdominal distension comes with vomiting alimentary. Laboratory investigations indicated: respiratory acidosis (pH: 7.07) with hypercapnia at 91 mm Hg, a PaO₂ at 135 mm Hg and alkaline reserve at 36 mmol/l. The rest of biological examinations did not show any other specific abnormalities.

A chest X ray in a semi-upright position showed homogenous radio-opacity with complete collapse of right lower lobe, thickened caesuras and mediastinal deviation. The first hypothesis was a decompensation of Chronic Obstructive Pulmonary Disease (COPD) complicated of respiratory acidosis caused by a viral infection. The patient had an antibiotherapy probabilistic, corticosteroid therapy and non- invasive ventilation (VNI) with favorable evolution. Chest CT thorax realized following an acute episode revealed in axial air fluid level and established the diagnosis of herniation of large bowel into the right hemithorax in coronal section (Figure 1). A posterolateral thoracotomy procedure was performed which involved the reduction of paraesophageal hernia without bowel resection into the abdominal cavity, excision of the hernia sac, a suture repair of crural pillars and diaphragmatic plicature (Figure 2). The patient had an uneventful post-operative recovery. In the immediate post-operative period, the patient had a daily chest physiotherapy and non-invasive ventilation session. The chest X-ray showed a good re-expansion of the right lung with disappearance of intra-thoracic herniation authorizing the removal of chest drains early on 3 day and 4 day postoperatively. No recurrence was noted after 6 months of decline.

Complex hernia paraesophageal (type-IV) which contains abdominal viscera herniating through the hiatus into the thoracic cavity other than the stomach represents at most 5-15% among 6 all the other types [1]. There are particularly likely to incarcerate and cause symptoms of intermittent epigastric pain [2]. Image of compressive air-fluid level in chest X ray should lead to the elimination of a pulmonary abscess and other aetiologies of hydropneumothorax with a risk of chest drainage and visceral perforation [3]. Today, symptomatic paraesophageal hernias are recommended for repair [4]. The majority of published reports suggest that laparoscopic repairs with less pain are favored compared to an aggressive surgical approach [4,5]. Current practice favors a laparoscopic approach,

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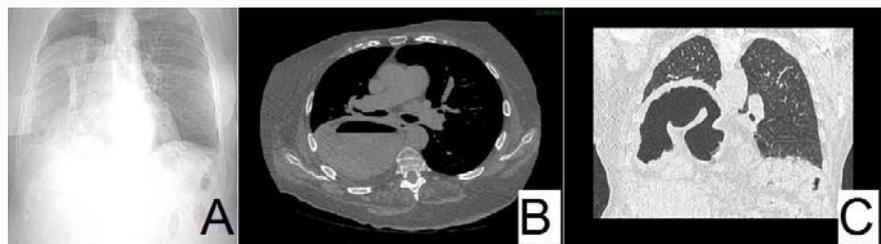


Figure 1: a) CT to program shows herniation of the liver and large bowel loops into the right hemithorax, with a shift of the heart and mediastinum to the left side caused by herniation. b) Axial CT scan image shows a giant right-sided thoracic air-fluid level indicating obstruction and slight mediastinal shift. c) Coronal CT scan image demonstrating herniation of bowel loops and liver in the right hemithorax through the large diaphragmatic defect.



Figure 2: Operative photograph: reparation (plicature) of the diaphragmatic defect visualized at thoracotomy.

complete sac excision, primary crural repair with or without use of mesh, and a routine fundoplication. Transthoracic repair avoids the previous operative field (fascial retraction and visceral adherence) in abdominal surgery patients as in our observation [6,7]. The possibility of a strangulation of a diaphragmatic hernia should be systematically borne in clinician's mind before an image air-fluid level intra thoracic associated at non-febrile digestive symptomatology. Imaging examinations should in no case delay surgery.

Author Contribution

Data curation: Razafimanjato Nnm. Investigation: Razafimanjato Nnm, Ravoatrarilandy M. Writing - original draft: Razafimanjato Nnm, Ravoatrarilandy M. Writing - review & editing: Rakotovao Hjl, Y Castier.

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