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Letter to Editor

Oncology Section

Post Esophagectomy Hiatal Hernia; Expect the Unexpected

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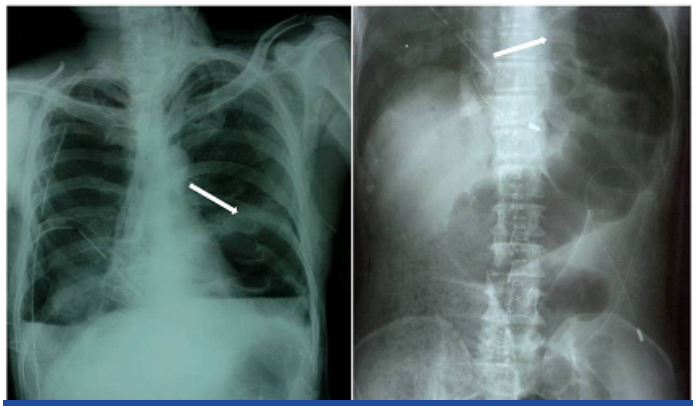
We report a case of a 60-year-old gentleman who underwent transhiatal esophagectomy with gastric pull up and cervical oesophagogastric anastomosis for adenocarcinoma of lower end of oesophagus. The patient was started on jejunostomy feeds on third postoperative day (POD), which was gradually increased to full feeds by seventh POD. On eighth POD, he developed chylothorax and hence jejunostomy feeds were stopped. On tenth POD he developed intestinal obstruction. Chest and abdomen X-ray showed bowel loops in the left thorasic cavity [Table/Fig-1]. He underwent emergency laparotomy and was found to have herniation of transverse colon into left thorasic cavity through the hiatal defect. The contents were reduced and repair of the hiatal defect done. The colon showed congestion but peristalsis was noted. The patient subsequently developed septicaemia and multiorgan dysfunction and succumbed two days later.

Hiatal hernia (HH) is an under-reported and potentially fatal complication, accounting for 0.3 - 4% of esophagectomy cases. It can follow trans thoracic or trans hiatal esophagectomy; may be immediate, early or delayed. The presentation can be myriad, with respiratory distress, intestinal obstruction, strangulation, chest pain or may be asymptomatic. A high index of suspicion is essential for prompt management [1].



[Table/Fig-1]: Chest and abdomen X-ray PA showing bowel loops (arrow) in left thorasic cavity

Although anastomotic leak and pulmonary complications are known to occur following esophagectomy, HH is uncommon. It most frequently occurs into the left hemithorax. An important predisposing factor is excessive manipulation of the hiatus during surgery or resection of a portion of diaphgram for tumour clearance [2]. Imaging plays a pivotal role in recognition of HH. Chest X-ray confirms the diagnosis by presence of bowel loops in thorasic cavity. Ultrasonography has been shown to be useful, but multislice CT is most sensitive as it gives excellent anatomical details on contents of hernia and its complications such as strangulation [3]. Delayed diagnosis can lead to strangulation and perforation of bowel and high risk of mortality. Repair of HH by re-approximating the diaphragmatic crura and hitching the conduit to diaphragm may be performed. The defect may require repair using mesh prosthesis [4]. It is important to completely mobilize the crura posterior to the conduit, so that hiatus can be closed without tension. Recurrence rate after repair was 29% [5].

To conclude, HH is a rare but preventable complication of oesophageal surgery. For patients with gastrointestinal or pulmonary symptoms, an aggressive management approach should be pursued. Successful management depends on early diagnosis and timely surgical intervention.

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