51. PARAESOPHAGEAL HERNIA COMPLICATED WITH GASTRIC STRANGULATION

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Introduction. Paraesophageal hernias are usually asymptomatic, but in the presence of symptoms, the clinical picture is dominated by compression syndrome. Consequently, dramatic complications such as incarceration, obstruction, ischaemia and perforation of the herniated viscera can develop, resulting in high mortality.

Case presentation. Patient G., 65 y/o, is presenting primarily on 03.01.19 with the following complaints: dyspnea, retrosternal pain, nausea, vomiting, general weakness, dizziness. Bilateral pneumonia is suspected. Physical examination: BP – 120/80mmHg, HR – 98bpm. A paraesophageal hiatal hernia with herniation of the stomach into the chest cavity is found after plain chest X-ray and Barium swallow X-ray. Blood tests show anemia and leukocytosis: Hb – 55g/l, erythrocytes – 2,5x109/l, leukocytes – 16,8x106/l. Biochemical profile – within normal limits. The patient categorically refuses hospitalisation. On 09.02.19 she was brought again by EMS, in severe general condition, with the same complaints and preventive diagnosis of acute abdomen. Barium swallow X-ray is performed, which shows a hiatal hernia with partial transposition of the stomach into the chest cavity on the right, free air in the peritoneal cavity. USG shows pleural effusion on the right ≈ 500ml. As she is hemodynamically unstable: BP – 80/40mmHg, HR – 110, she is transferred to the ICU for preoperative preparation. Urgent surgical treatment is indicated. It is performed on 10.01.19, 16:55 - 20:35. During laparotomy, paraesophageal herniation of the stomach into the thoracic cavity with necrosis on the greater curvature and perforation of the chronic duodenal ulcer, signs of peritonitis were noted. In connection with this, "Resection of the large curvature of the stomach, suture of chronic perforated duodenal ulcer, recalibration of the esophageal hiatus with application of retrocolic gastro-enterostomy and drainage of the peritoneal cavity" was performed. The patient continues the post-operative treatment in the ICU, but remains in severe condition with progressive evolution of polyorgan failure. On the 3rd postoperative day, failing all resuscitation efforts, biological death occurs.

Discussion. This case demonstrates the lethal potential of paraesophageal hernia complications. The patient's complaints at first admission and the results of radiological examination suggested this diagnosis. The patient's refusal to be admitted postponed the surgery for a week, her general condition worsening significantly on the repeated visit. Nevertheless, the procedure was performed, the necrotic portion was resected and the diaphragmatic defect repaired. Postoperative, the patient presented negative dynamics, after which death occurred 48 hours later.

Conclusion. In case of paraesophageal hernias, surgical treatment must be initiated as early as possible before fatal complications develop.