

PICTURES IN DIGESTIVE PATHOLOGY

Gastric necrosis secondary to strangulated giant paraesophageic hiatal hernia

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INTRODUCTION

Asymptomatic giant hiatal hernia comprises a relatively common disease, mostly presented in women at the age of 50 and older. The therapeutic approach remains controversial in recent years.

CASE REPORT

A 67-year-old woman with a medical history of morbid obesity, type 2 diabetes mellitus, arterial hypertension, dyslipemia, and an asymptomatic hiatal hernia is admitted to our hospital owing to thoracic and abdominal pain, which has been related to food intake for 6 months. The patient presents a clear worsening in the last 48 hours, with no other associated symptomatology. With the suspected diagnosis of acute pancreatitis, the patient is admitted to the Digestive Service.

Twenty four hours after admission, the patient presents an overall worsening, with hypotension, tachycardia and profuse sweating. The CT scan shows a hiatal hernia with a mesentero-axial stomach volvulus inside. Gas and abundant periesophageal liquid are also observed. These findings are compatible with the diagnosis of an incarcerated and ischemic paraesophageic hiatal hernia with a stomach perforation (Fig. 1).

CT scan also shows moderate amount of perihepatic, perisplenic liquid (Fig. 2). Suspecting an incarcerated hiatal hernia with stomach perforation, the patient is taken to the operating room for a laparotomy during the early hours.

An atypical gastrectomy of the greater curvature with a gastropexy is performed along with fixation to the anterior abdominal wall. Surgery is completed with a feeding jejunostomy.

During the postoperative period, the patient has a mediastinal collection, which is treated conservatively with antibiotics. The patient is discharged after 12 days.

DISCUSSION

Gas-filled viscus in the lower chest or upper abdomen on chest radiograph is diagnostic of a paraesophageic hernia.

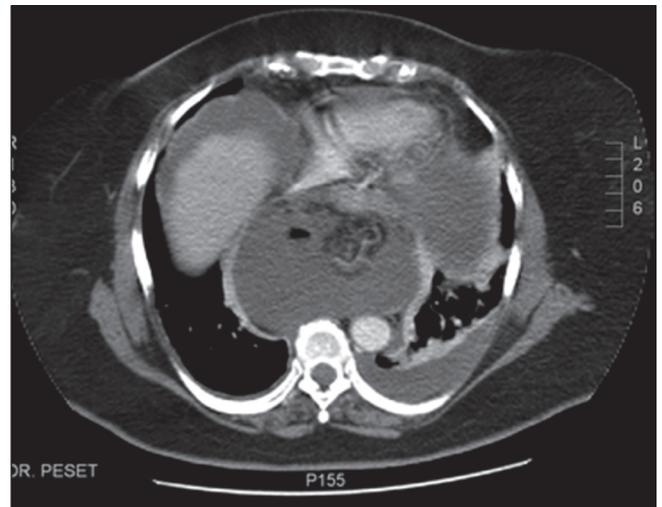


Fig. 1. Transverse section of a CT scan, showing a large hernia sac in posterior mediastinum with abundant liquid inside.



Fig. 2. Coronary section of a thoracic-abdominal-pelvic CT scan showing the giant paraesophageic hiatal hernia.



Fig. 3. P-A chest radiograph showing a fluid level in thorax.

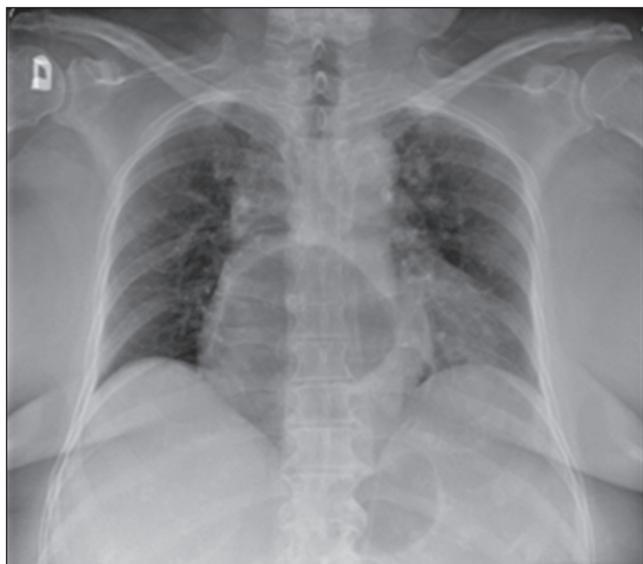


Fig. 4. P-A chest radiograph showing an increased amount of air in thorax.

In our case, we also objectified a progressive air increase inside the herniated stomach (Figs. 3 and 4). These findings support the suspected incarceration.

At present, upper endoscopy is the most sensitive and specific technique for this kind of disease.

CT findings make the diagnosis clear and can be very important in establishing the diagnosis when a clinician is aware of the severity of the presentation.

Hiatal hernia emergency surgery technique is actually not still clearly established.

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