RADY 417 Case Presentation

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Patient: Ms. M is a 42 year old female with PMH of asthma and psychiatric illness (limited history given) that presents with 6 month history of heartburn, dysphagia, and regurgitation. No history of abdominal or esophageal surgery.

No previous imaging available.

No labs.
Differential Diagnosis for Dysphagia

- Esophagitis (pill, infectious, eosinophilic)
- Esophageal rings/webs
- Esophageal motility disorder impairing peristalsis (eg, achalasia)
- Hiatal hernia
- Stricture
- Esophageal carcinoma
- Cardiovascular abnormalities
Imaging studies obtained

Barium swallow
Barium swallow showed tertiary peristaltic waves and a moderate sliding hiatal hernia with delayed passage of contrast into the stomach secondary to a small bend of the distal esophagus adjacent to the hernia.
FINDINGS:
The patient was given oral contrast to swallow which the patient did without difficulty.

The esophageal mucosa was normal in appearance, with no mucosal lesions, ulcerations, polypoid filling defects or strictures. Tertiary peristaltic waves were noted on static imaging. There was a moderate sliding hiatal hernia with delayed passage of contrast into the stomach secondary to a small bend of the distal esophagus adjacent to the hernia. There was no esophageal ring, web or achalasia. There was spontaneous gastroesophageal reflux to the level of the proximal esophagus.

The patient was given a 12.5 mm barium tablet which passed without difficulty.

Evaluation of the cervical esophagus with videofluoroscopy and rapid filming was unremarkable.

The remainder of the partially included chest, including the cardiomediaastinal silhouette, lungs, bones and soft tissues were normal. Status post internal fixation of multiple right ribs.
Moderate sliding hiatal hernia seen. There was spontaneous gastroesophageal reflux to the level of the proximal esophagus.
Discussion: Hiatal Hernia

○ Clinical Manifestations
  ○ Large Type I hernias: may have symptoms of gastroesophageal reflux disease (GERD), including heartburn, regurgitation, and dysphagia
  ○ Types II-IV: either asymptomatic or intermittent symptoms, including epigastric/substernal pain, postprandial fullness, nausea, and retching
Types of Hiatal Hernia

- **Type I**: Referred to as sliding hiatal hernia; GE junction migrates above diaphragm, stomach remains in longitudinal alignment, fundus below GE junction
- **Type II**: Paraesophageal hernia; GE junction is in normal anatomic position, but portion of fundus herniates through diaphragm hiatus adjacent to esophagus
- **Type III**: Combination of I and II where both the GE junction and fundus herniate through the diaphragmatic hiatus with the fundus above the GE junction
- **Type IV**: Presence of a structure other than the stomach (eg, omentum, colon, or small bowel) within the hernia sac
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Diagnosis of Hiatal Hernia

**TYPE 1 (SLIDING) HH**
- Can be seen by barium swallow, endoscopy or esophageal manometry if they are larger than 2 cm in the axial span
- If less than 2 cm, these studies are unreliable for diagnosis as the GE junction is very mobile

**PARAESOPHAGEAL HERNIA**
- Barium swallow is the most sensitive diagnostic test; however, it can also be diagnosed by upper endoscopy
Management of Hiatal Hernia

- Do not need to surgically repair asymptomatic type I hiatal hernia; medically manage GERD symptoms with PPIs/H2 blockers
- In the case of asymptomatic paraesophageal hernias, management is controversial, although most agree that surgery is not indicated
- Symptomatic paraesophageal hernias should be repaired surgically.
- In patients with the following symptoms: gastric volvulus, uncontrolled bleeding, obstruction, strangulation, perforation, and respiratory compromise secondary to the hernia, emergent repair should be done