INTRODUCTION

Hiatal hernias involve the herniation of part of abdominal contents through the esophageal hiatus of the diaphragm. There are four types: type I or sliding hiatal hernia, type II or paraesophageal hiatal hernia, or mixed type III and type IV, in which ascend to the chest organs like the colon and spleen (1).

CLINICAL OBSERVATION

A 67 year-old-woman was admitted to the Gastroenterology Department to study microcytic anemia, and heartburn. She had a hemoglobin of 6.4 g/dL, MCV 61 μm³ and profile of iron deficiency. We performed a gastroscopy, which revealed a large hiatal hernia with a mixed component and a tarnished mucosa in the fundus, antrum and body. The barium radiological study demonstrated a horizontalization of the stomach in the mediastinum, with the gastric body and greater curvature at the level of tracheal carina and the gastroesophageal junction at the level of gastric fundus (lower gastric body). In addition, it presented a marked delay in the elimination of contrast through the pylorus. We did not identify the left hemidiaphragm. Then it was decided to request a chest computed tomography, which confirmed the findings. It was proposed surgical repair of large mixed hernia with possible risk of volvulus, but the patient refused surgery. She is currently asymptomatic.

DISCUSSION

The repair of sliding hiatal hernias is indicated only in case of large hernias that cause symptoms of GERD refractory to medical treatment. By contrast, hiatal hernia types II, III and IV should be repaired early, even in the absence of symptoms, because of the risk of potentially serious complications such as volvulus of the stomach (1-3). In our case, the patient repeatedly refused surgical treatment and remains asymptomatic.
REFERENCES