The usefulness of transhiatal access is a new recognition of the modern oesophageal surgery [1–5]. We present a patient with a complex mediastinal pathology managed by this way.

A 68-year-old man has been admitted for massive haematemesis which had subsided on conservative therapy. Chest X-ray showed a lower-posterior retrocardiac shadow on the right side. On CT scan a huge (8 × 5 cm) well delimited mass in lower-posterior mediastinum at the right side of the vertebral column was seen. On the barium meal examination incarcerated massive hiatal hernia [4] secondary short oesophagus and intramediastinally penetrating high lesser curvature ulcer was discovered. The ulcer proved to be benign on histological examination. In addition slight oesophagitis and reduction of FEV1 with 30% has been detected.

The basic problem was which is the best approach for a histologically not verified, lower-posterior, presumable benign mediastinal tumor associated with a complicated hiatal hernia?

To reduce the magnitude of intervention one-stage transhiatal approach was decided.

Through a midline laparotomy, the vertically enlarged hiatus provided a comfortable exposure for both lesions. Dissection of the incarcerated and firmly adherent advanced hiatal hernia and of the short oesophagus from the periesophageal attachments was extensively done. The following step was removal of an encapsulated, huge lipomatosus mass from the posterior mediastinum, extending high on the right side of the vertebra, arising from the lesser curvature of the stomach. The penetrating high lesser curvature ulcer was then excised and sutured. Finally a Toupe type 270° posterior, tension-free, abdominal fundoplication and fundopexy around the reconstructed hiatus was carried out.

The 7-day contrast material examination showed abdominal position of the stomach and absence of reflux. The patient was discharged at that day with a normal chest X-ray. Histopathologically the tumor was a benign fibrolipomatosis. The follow-up period was free from recurrence. Transhiatal approach has been advocated previously for management of several oesophageal problems [1–4] and recently for closure of spontaneous rupture [5].

Regarding to our patient with such a complex pathology our intention was to use instead of a combined left or right thoracoabdominal approach a limited invasive and well tolerable access. The enlarged transhiatal rout proved to be a useful exposure for both mediastinal and abdominal diseases and subsequent surgery. Nevertheless the benign nature of the encapsulated pseudotumor and its easy dissection from the surrounding mediastinal tissue was an important prerequisite to perform resection by this way.

As regard to the type of fundoplication used, after a previous extended dissection of the lesser curvature with subsequent, supposed disturbance of gastric wall vascularization, creation of a conventional Collis gastroplasty tube and fundoplication seemed to us dangerous. Therefor abdominal partial posterior fundoplication (Toupet type) was performed The value of our option has been confirmed by the uneventful postoperative course.

This experience suggests that for some particular lower-posterior mediastinal, oesophageal or thoracoabdominal problems transhiatal access through the enlarged hiatus seems to be a useful alternative or even superior of traditional mediastinal approaches.

References

