We read with interest and wish to congratulate Dr. Makhija et al. [1] on their reported case on delayed cardiac tamponade following posttraumatic diaphragmatic hernia without an intrapericardial component.

We wish to report a similar case presented with tamponade with an intact hemidiaphragm following right phrenic nerve palsy and known as Chilaiditis syndrome. Radiologist Demetrius Chilaiditis described in 1910 the homonymous sign consisting of hepatodiaphragmatic interposition of the transverse colon. The incidence of this anomaly varies between 0.025 and 0.28 percent in the general population. In the event of occurrence of respiratory or abdominal symptoms then it is called Chilaiditis syndrome.

In our case a 75-year-old male was admitted for syncope. Two years before he underwent a coronary artery bypass grafting through a median sternotomy. His surgery was complicated by right phrenic nerve palsy, followed by interposition of the transverse colon between the diaphragm and the liver. On admission the patient was dyspnoeic with distended jugular veins. A transthoracic echocardiogram (ECHO) revealed severe compression of the right heart chambers and was confirmed by chest CT. Pulsed Doppler ECHO showed a tricuspid valve flow velocity paradox of 75%, consistent with tamponade physiology. The patient was referred for diaphragmatic plication.

The incidence of post-sternotomy diaphragmatic paralysis varies between 1.4–5.4%, Chilaiditis syndrome being a potential complication of the latter [2]. There are only a few case reports of Chilaiditis syndrome presenting with acute abdomen or dyspnoea. Tamponade is an extremely rare complication of the above syndrome necessitating further surgical intervention.

References
