An unusual cause of dyspnoea

A 60-year-old lady who lived in a sheltered accommodation presented to hospital with a 6-week history of progressive shortness of breath. She was able to walk about 30 yards, but was breathless at rest on admission. Except for dry cough for 4 days, there were no other respiratory or cardiovascular symptoms. There was no history of trauma. On examination, the mediastinum was shifted to the right. In addition, the left hemithorax was resonant with reduced air entry.

Chest X-ray suggested differential diagnoses of a large diaphragmatic hernia or multiple bullae. This lady was intubated before a computed tomography (CT) scan that confirmed a large left-sided diaphragmatic defect through which a grossly dilated stomach, small bowel, large bowel and spleen had herniated. She underwent thoracotomy and hernia repair with reduction of abdominal contents. After a period of convalescence, she was discharged from hospital.

Large symptomatic and diaphragmatic hernias in the absence of trauma are very rare in adults. Majority of diaphragmatic hernias in adults (85%) are on the left side. Small Bochdalek’s hernias that are posterolateral diaphragmatic defects may remain asymptomatic for life. Widespread availability of CT and magnetic resonance imaging have led to increasingly frequent diagnosis of such hernias.

Although this lady did not have a history of trauma, it is well-recognized that diaphragmatic hernias may become symptomatic months or years after initial injury. Following a minor rupture, the negative pressure gradient between the peritoneal and pleural spaces favours progressive herniation of the bowel. Intermittent respiratory or gastrointestinal symptoms may precede a catastrophic presentation with dyspnoea or bowel obstruction and infarction.
Figure 3. CT-coronal section.

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References