Gastro-intestinal

Laparoscopic treatment of type III para-oesophageal hernia

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Summary
Type III congenital para-oesophageal hernia is a rare condition in children and is characterised by the herniation of both a substantial portion of the stomach and the gastro-oesophageal junction into the chest. This report describes the laparoscopic repair of 4 para-oesophageal hernias in children between 2002 and 2010. All hernias were treated successfully using the laparoscopic method. There were no recurrences. The laparoscopic repair of a para-oesophageal hernia is technically challenging, but is feasible and safe in the hands of paediatric surgeons familiar with laparoscopic anti-reflux surgery.

Congenital type III para-oesophageal hernia is a very rare condition characterised by the herniation of both a substantial portion of the stomach and the gastro-oesophageal junction into the chest. This abnormality can be explained on an embryonic basis, the presence of a right pneumoenteric recess or an abnormality of the lumbar component of the diaphragm, which developed from the mesoderm around the aorta. Most patients are symptomatic and present with vomiting and reflux symptoms, or acute complications which include volvulus, perforation and bleeding. Surgery is always indicated, either to prevent complications or to treat symptoms. Since this is a rare problem, few reports have been published on the laparoscopic technique. We present our experience in the laparoscopic treatment of 4 patients with type III para-oesophageal hernias. Between 2002 and 2010 we conducted 4 laparoscopic repairs in children with type III para-oesophageal hernias. There were 3 boys and 1 girl. Two of the patients were neonates, and the other 2 were aged 10 and 12 months, respectively. One of the patients had an associated Pierre Robin syndrome. The neonates presented with vomiting and the other 2 with chronic lung problems secondary to reflux.

Surgical procedure
The patients were placed in a supine position. Five 3 mm or 5 mm ports were used, depending on the size of the babies. In all the patients the stomach was incarcerated in the chest. Partial organo-axial volvulus was present in 2 patients. The operation was started by pulling the stomach into the abdomen. The hernia sac was then removed from its attachments and resected. Extensive mobilisation of the oesophagus was necessary in order to place the gastro-oesophageal junction 2 - 3 cm below the diaphragm. No short oesophagus was present in any of our patients.

Reconstruction of the hiatus was done by approximating the left and right crura posteriorly with interrupted Ethibond sutures. In all cases the crura were flexible and could be closed without excessive tension. Two to four sutures were placed between the oesophagus and the left and right crura to prevent the stomach from migrating back into the mediastinum. Because of the mobility of the stomach, it was not necessary to ligate the short gastric vessels.

A retro-window was developed through which the fundus was pulled. A 2 - 3 cm wrap was formed around an intra-oesophageal stent and secured with 2 - 3 non-absorbable sutures. We did not fix the wrap to the crura or the oesophagus. We also placed sutures between the oesophagus and the crura to secure the oesophagus in the intra-abdominal position and obliterate the space between the oesophagus and the crura to prevent migration of the wrap into the chest.

An anterior gastropexy was performed in 3 patients to prevent recurrence of the hernia and volvulus of the sometimes very mobile stomach, and a gastrostomy in 1. Two small stab incisions were made in the anterior abdominal wall. Two non-absorbable sutures were placed through the abdominal wall and the anterior gastric wall. The suture was grabbed with a wound closure device and pulled to the outside, tied extracorporeally and buried in the subcutaneous tissue. Care was taken not to place the sutures too close to the wrap to prevent any tension on the wrap.

Results
Operative time ranged from 95 to 125 minutes. There were no intra- or postoperative complications. No blood transfusions were necessary. Oral feeds were started within 6 hours postoperatively. Three patients were discharged on the 3rd postoperative day. The 4th patient, with Pierre Robin syndrome, remained in hospital for 24 days because of problems not related to the laparoscopic surgery. Postoperative follow-up ranged from 4 months to 8 years. No symptomatic or radiological recurrence has occurred.

Discussion
Laparoscopic repair of para-oesophageal hernia is established in adults, but the literature in children is limited and several issues regarding operative technique are unresolved. There is a high rate of recurrence, with an incidence of 10 - 40% in adults with both open and laparoscopic approaches, and many techniques...
have been developed to reduce this. These include anterior
gastropexy, gastrostomy, fixation of the fundoplication and
different techniques of crural repair.²,⁸,⁹

It is important to remove the sac to facilitate proper closure
of the hernia. Its removal also prevents traction on the stomach
that might lead to recurrence. Care must be taken not to injure
the vagus nerve, blood vessels or pleura. The laparoscopic
method provides excellent vision to identify these structures.⁹,¹⁰

To prevent undue angulation of the oesophagus, anterior
crural sutures can be placed to close the defect. It is important
not to damage the peritoneal layer on the crura during initial
dissection, as this layer adds strength to the repair. Prosthetic
material to close the defect was not needed in any of our
patients. Serious complications (stricture, or erosion into the
oesophagus) have been described with the use of prostheses,
and many surgeons are reluctant to use them. The new types of
biosynthetic mesh should cause less oesophageal injury.¹¹

A high incidence of gastro-oesophageal reflux is present in
patients with type III hernias, and an anti-reflux procedure is
essential.¹² This is supported by Yazici et al.¹³ and Karpelowsky
et al.,¹⁴ who reported an incidence of reflux of 60 - 68%. The
reasons for this are the abnormal anatomy, as well as the
extensive dissection and mobilisation, which destroy the
mechanisms that control reflux.⁵,⁵

Laparoscopic repair of a para-oesophageal hernia is
technically challenging, but is feasible and safe in the hands
of paediatric surgeons familiar with laparoscopic anti-reflux
surgery. It has all the advantages of laparoscopic anti-reflux
surgery, including less pain, shorter recovery and hospital stay,
as well as no postoperative ileus. An important advantage of
the laparoscopic approach, especially in the para-oesophageal
hernia, is the superior vision provided by the laparoscope in
identifying important structures at particular risk during this
procedure.

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