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Obstructed Left-Sided Morgagni Hernia: A Case Report and Literature Review

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Introduction

Morgagni hernia (MH) is a rare type of congenital diaphragmatic hernia (CDH) and accounts for 2-3% of all diaphragmatic hernia. Incarceration or obstruction in Morgagni hernia are uncommon presentation of this condition

Case Report

A 40-year-old obese gentleman presented to us with recurrent visit for worsening abdominal pain and symptoms of bowel obstruction associated with exertional dyspnoea. Chest X-ray showed presence of left paracardiac shadow with bowel loops in the left thorax. Urgent CT revealed an obstructed left Morgagni hernia for which he underwent an emergency surgery for reduction of the contents and repair of the hernia defect. The defect was repaired primarily with non-absorbable interlocking sutures with a polypropylene mesh placed over the repair site with the parietal peritoneal layer closed over the mesh. Post-operatively he was nursed in ICU for post-operative atelectasis and recovered well. He was discharged on day 6 and remained well on follow up visit to our clinic in 2 months with no evidence of hernia recurrence.

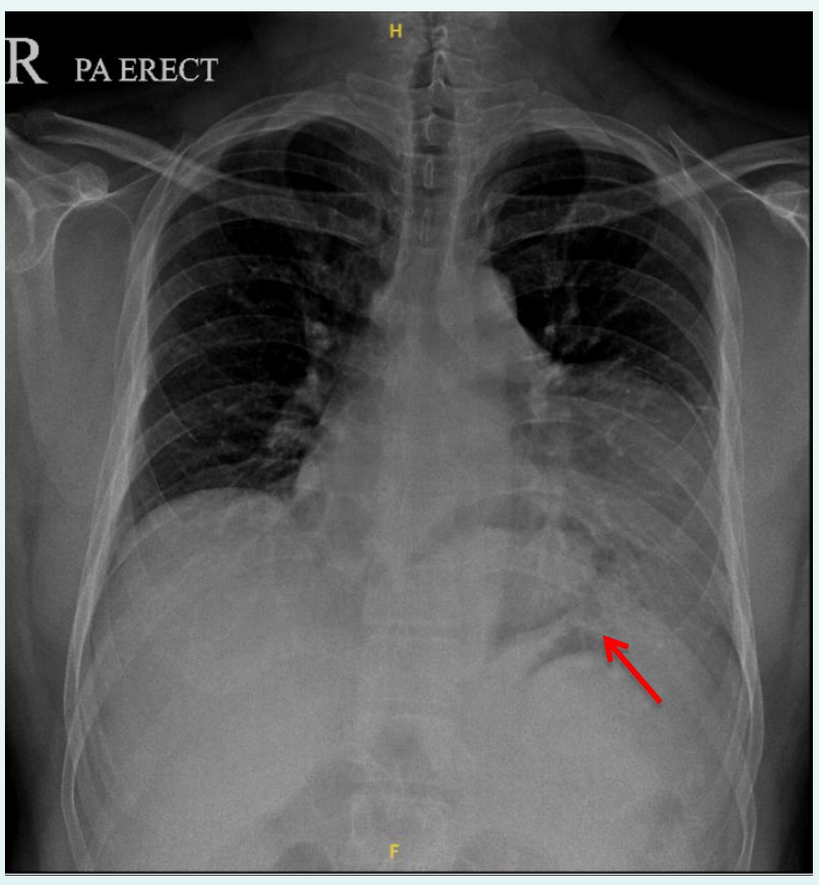

Figure 1: CXR on presentation showed presence of left sided para-cardiac shadow (red arrow) which is pathognomonic of bowel herniation into the thoracic cavity.

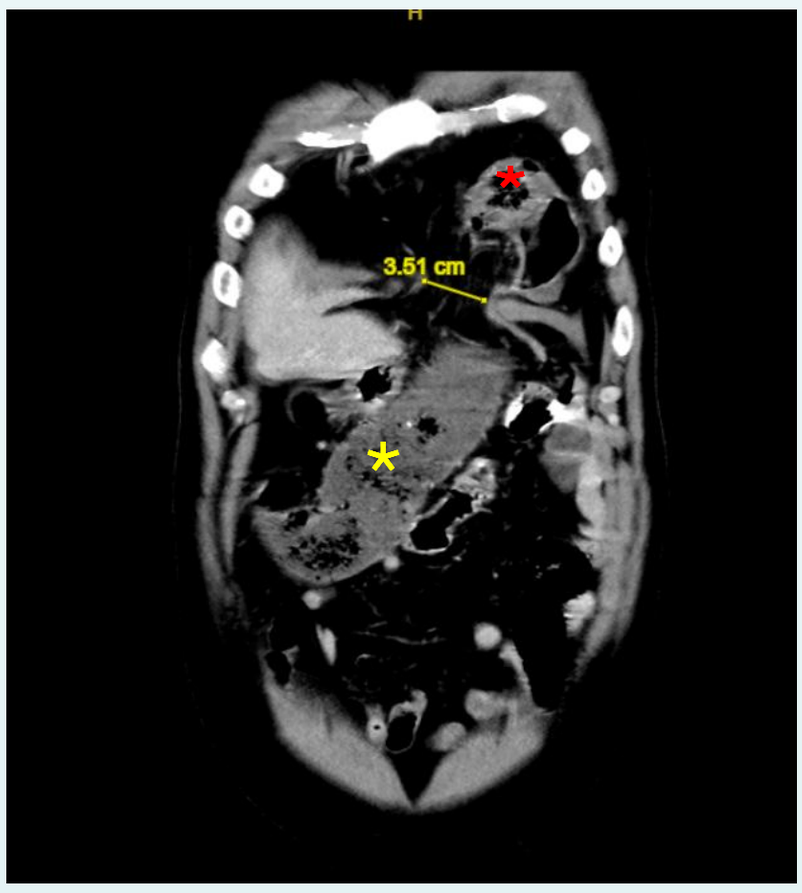

Figure 2: CECT AP (coronal view) Hernia contents (red star) within the left thoracic cavity consisting of omentum and part of transverse colon with proximal colonic dilatation (yellow star).

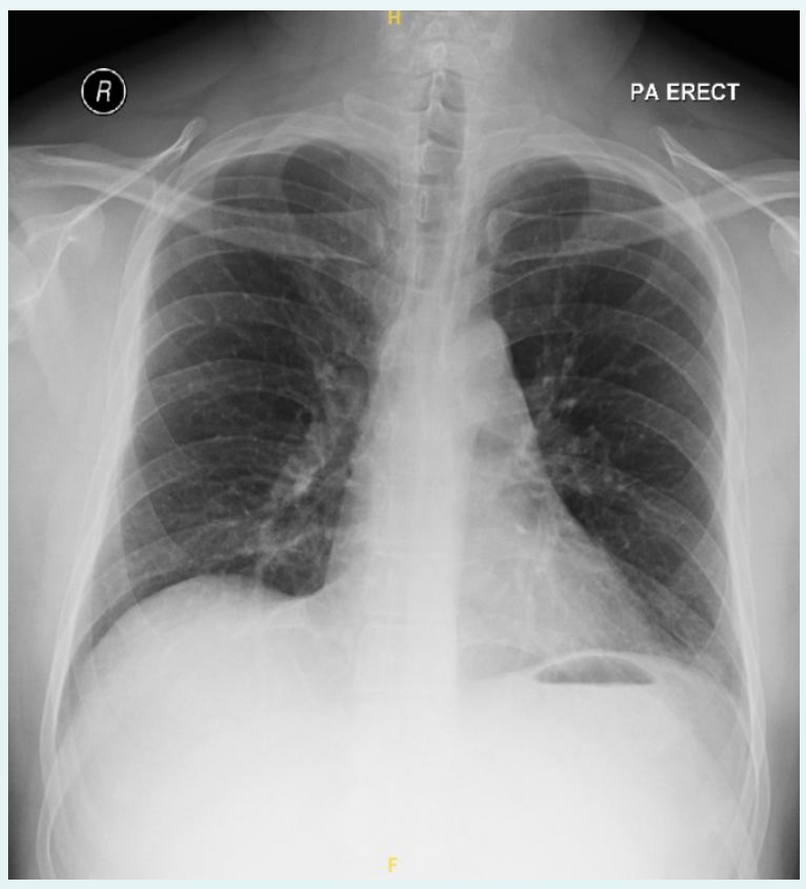

Figure 3: CXR during clinic review on 2 months post surgery with well expanded lungs bilaterally.

Discussion and Conclusion

This case demonstrated the challenge in diagnosing MH as it mimics pulmonary infection which resulted in the revisit to hospital with bowel obstruction. Morgagni Foramen is a defect in the costosternal trigone that is usually small and asymptomatic but can potentially increase in size over time and lead to non-specific abdominal and respiratory symptoms. A high index of suspicion is required for early diagnosis to prevent complications such as bowel strangulation or perforation. Transabdominal is the preferred approach for surgery with a recent paradigm shift towards laparoscopic repair. However, laparotomy is still the preferred approach in patients who present with gross bowel dilatation and those who are unstable to tolerate pneumoperitoneum.

References

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