Berwick Colorectal & Surgical Specialists

HIATUS HERNIA

What is a hiatus hernia?

A hiatus hernia is where contents of the abdominal cavity protrude through the oesophageal hiatus. Typically, the oesophageal hiatus only allows the oesophagus to pass through a defect in the diaphragm.

Following ingestion, food and liquids pass through the hiatus into the stomach and are usually prevented from refluxing back into the oesophagus through several in-built mechanisms. These include a muscle present at the junction between the oesophagus and stomach known as the lower oesophageal sphincter. Failure of this mechanism leads to reflux.

What are the different types of hiatus hernias?

Hiatus hernias are broadly described either as sliding or para-oesophageal hernias. A sliding hernia is where the junction between the oesophagus and stomach is displaced above the diaphragm.

Alternatively, a para-oesophageal hernia occurs when part of the stomach is also displaced above the diaphragm.

What are the symptoms?

Some patients do not have any symptoms at all, and a hiatus hernia is discovered incidentally on imaging or at gastroscopy. Symptoms when present include:

Sliding hiatus hernias

- Heartburn: burning discomfort in the upper part of the abdomen, radiating beneath the sternum (breastbone). At times there is an acid sensation in the mouth. These symptoms typically occur at night and when lying down, bending, or straining.
- Upper abdominal pain

Para-oesophageal hiatus hernias

- Heartburn: burning discomfort in the upper part of the abdomen, radiating beneath the sternum (breastbone). At times there is an acid sensation in the mouth. These symptoms typically occur at night and when lying down, bending, or straining.
- Upper abdominal pain
- Difficulty swallowing or the sensation of food becoming stuck.
- Feeling full easily
- Regurgitation of food and liquids
- Nausea, retching
- Symptoms of anaemia (dizziness, feeling lightheaded, short of breath, feeling tired)
- Feeling short of breath

What tests are required?

Gastroscopy to exclude other abnormalities followed by a barium swallow for select patients. A barium swallow is a dynamic X-ray where you are asked to drink contrast. This often confirms the diagnosis and is useful for surgical planning.

For some patients with reflux symptoms, oesophageal manometry and 24-hour pH studies are required to confirm the diagnosis. This procedure requires a device to be placed through your nose and into your stomach where the pressures in your oesophagus are measured and the levels of acid. The device placed remains for 24 hours delivering data to a computer which is used to diagnose reflux.

What are the options of management?

Conservative (medical) or surgical. Conservative or non-operative options are usually recommended for a sliding hiatus hernia and include medical treatment and lifestyle changes. Alternatively conservative options for a para-oesophageal hiatus hernia is typically recommended for patients who are frail, elderly, have multiple medical problems, asymptomatic or who refuse surgery.

For reflux symptoms, medical therapy includes antacids and regular administration of an anti-reflux medication that aims to reduce acid production known as a proton-pump inhibitor (PPI). On occasion this medication can be combined with other treatmens that aim to reduce acid production. Lifestyle measures includes weight loss, avoiding food and liquids that aggravates reflux symptoms, meal consumption earlier in the day and

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elevating your head and neck when lying down with multiple pillows.

Surgical management for both types of hernia is performed predominantly laparoscopic (keyhole). For a sliding hernia an anti-reflux procedure is performed, and the upper part of the stomach folded around and sutured to itself (fundoplication) with or without repair of a hiatus hernia if present. Similarly, a fundoplication is also performed in patients with a para-oesophageal hernia together with repair of the hiatus hernia.

Rarely, the surgery cannot be completed laparoscopically. In that instance, an incision measuring approximately 20-30 cm in length in the upper part of the abdomen is made.

What are the possible complications?

Minor complications from the procedure include infection of the wounds which requires dressings and antibiotic treatment. More significant complications include

- Difficulty swallowing: Usually temporary. Occasionally additional procedures are required for correction.
- Bloating
- Bleeding: Major bleeding requiring transfusion or a return to theatre is uncommon.
- Damage to the oesophagus, stomach, liver and is rare and will require additional procedures.
- Recurrent symptoms despite surgery

What to expect following your procedure?

All patients remain in hospital for a minimum of two days. You will wake from anaesthesia with dressings over dissolvable sutures. It is anticipated to experience pain at the incision sites and occasionally in the right shoulder from the gas used to perform the procedure. This pain is easily managed with pain killers. It is also not uncommon for patients to experience nausea after their surgery which is controlled with medications. The laparoscopic dressings should remain intact for four days. The dressing is waterproof to splashes only. After four days, remove them yourself. If you are concerned, see your general practitioner in the interim.

You will be provided with a liquid diet initially in hospital and then progress to a pureed or sloppy diet under the supervision of the hospital dietician. You will remain on this diet for 4-6 weeks and will be provided with further instructions when you are allowed to progress. You may need to permanently alter your diet and avoid carbonated beverages depending on the procedure that is performed.

Gentle exercises are encouraged. You may drive if you are able to put your foot on the brake in an emergency or have ceased taking any painkillers. Usually this occurs after 1-2 weeks. Post-operative follow-up usually occurs in two weeks and will be arranged on discharge with your surgeon.

An open procedure will extend your stay from 3-5 days. You will awake from anaesthesia with a dressing over your incision covering dissolvable sutures. It is normal to experience pain from the procedure and require additional painkiller medications. It is also not uncommon for patients to experience nausea after their surgery which is controlled with medications. You will be encouraged to ambulate after surgery and will be discharged from hospital if you are tolerating a diet, able to pass urine, your pain is controlled with painkillers, and you are ambulating independently. The dressing should remain intact for seven days. The dressing is waterproof to splashes only.

Gentle exercises are encouraged. You may drive if you are able to put your foot on the brake in an emergency or have ceased taking any painkillers. Usually this occurs after 4-6 weeks. Post-operative follow-up usually occurs in two weeks and will be arranged on discharge with your surgeon.