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Commentary: Beware of the esophagus—it's never too late for a complication

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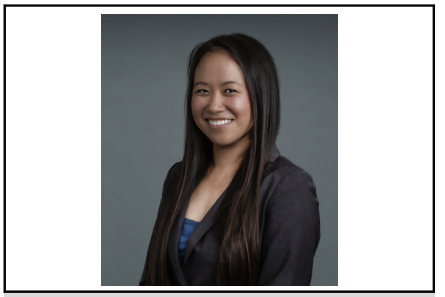

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CENTRAL MESSAGE

For patients with an esophagectomy, complications like paraesophageal or diaphragmatic hernias can arise years later. CT scan remains the gold standard for diagnosis of these complications.

Esophagectomy is a high-risk procedure with a significant risk of short-term and long-term morbidity.[1] The most common long-term complications include dysphagia, reflux, delayed gastric emptying,[2] and anastomotic strictures, whereas hiatal hernias are a rare complication occurring in <1% of patients after esophagectomy.[3] Patients with paraconduit hernias can be asymptomatic or present with cough, chest pain, dysphagia, or obstructive signs (ie, nausea, vomiting). For symptomatic patients, surgical repair is indicated. The median time to diagnosis of symptomatic paraconduit hernias was 21 months in one single-center study.[2]

In this case report, Watkins and colleagues[4] report the case of a 65-year-old female patient who had a late complication of a diaphragmatic hernia resulting in fecopneumothorax. Four years after neoadjuvant chemoradiation and minimally invasive esophagectomy, she developed left shoulder pain, with a normal chest radiograph. She was discharged from the emergency department but represented days later with respiratory distress and a fecopneumothorax. A computed tomography (CT) scan of the chest showed a diaphragmatic defect with colon, consistent with the strangulated colon that was seen in the operating room. This segment of colon was resected, and the diaphragmatic defect was repaired. This hernia was likely secondary to mobilization of the left triangular ligament for a liver wedge resection of a concerning lesion (final pathology was benign) at the time of her initial operation. The authors are to be commended since, despite this unusual complication, she recovered and was discharged home.

This case report describes another possible postesophagectomy complication. If liver mobilization is performed, there is a risk of diaphragmatic injury and subsequent hernias. Delay in diagnosis can result in incarcerated bowel becoming strangulated. As the authors point out, CT scan is the gold standard for diagnosing these rare complications. Even multiple years out, patients with previous esophagectomy who present with chest pain, shortness of breath, or obstructive symptoms should undergo a CT scan to rule out paraconduit or diaphragmatic hernias. Timely diagnosis is essential to preventing further complications, such as strangulation, perforated bowel, or even fecopneumothorax.

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