DISCUSSION

Endoscopic hemostasis of tumoral lesions is a challenging situation, since no endoscopic therapy has been proved to be superior\(^3\). Choice of therapy will be dictated by the tumor’s appearance and the personal experience of the endoscopist. Reports show that hemoclips have been applied in both successful\(^2\) and failed\(^4\) attempts to achieve hemostasis. In the present case, the tumor appeared to be friable and an attempt to apply hemoclips could have led to mucosal tearing and recurrent bleeding. Endoloop ligation of such lesions has been described to treat bleeding tumors and also to resect lesions in patients deemed non-surgical candidates, through ischemic necrosis (loop-and-let-go)\(^1\). Although the surgical approach is considered the treatment of choice for such lesions, the endoloop technique is a useful, feasible, cheap and safe alternative for patients considered unsuitable for surgery or as a temporary measure to stabilize patients before the surgical treatment.

REFERENCES

A 38-year-old man was diagnosed with diaphragmatic rupture eight months after being stabbed. Diaphragm repair was performed with left thoracotomy. The patient experienced no symptoms for six years postoperatively. However, severe abdominal pain extending to the chest, and dyspnea had started two years previously. The patient was diagnosed with recurring diaphragmatic hernia. However, he refused surgery and presented to hospital when the symptoms worsened. At physical examination, intercostal herniation increasingly marked with the Valsalva maneuver was observed in the left thoracotomy incision site. Intestinal sounds were heard in the left hemithorax. Computerized tomography (CT) of the thorax revealed hernia in the left hemithorax involving the transverse colon, omentum and small bowel (Figure 1a). Intercostal herniation in the old thoracotomy incision site at the 7th intercostal space was observed at the same time (Figure 1b). Laparoscopic repair was attempted. Intraoperatively a hernia defect 9x6 cm in size was determined, extending laterally from the center in the left hemidiaphragm (Figure 2). Dense adhesions between the hernia margins and the intestines were released with the LigaSure Vessel Sealing System (Valleylab, Boulder, CO, USA). The herniated intestines were easily reduced back to the abdomen with an atraumatic grasper. Primary suture was performed to the defect in the diaphragm was, and hernia repair was completed with C-core dual mesh. A dual mesh was identified with titanium tacker to the diaphragm. The thorax was drained with a No. 28 tube. Postoperative pain was controlled with 12 mg/h tramadol hydrochloride. The thoracic drain was removed on the 6th day. The patient was discharged on the 7th day. Pleural effusion was detected at control imaging the 21st day (d). No recurrence has been detected at control imaging over the last 22 months.

**DISCUSSION**

Traumatic diaphragmatic hernias may be classified as immediate or delayed, depending on post-injury time of determination. In the acute period, isolated diaphragmatic injuries are frequently asymptomatic, and accurate diagnosis is made in only 30-40% of cases. With the exception of small injuries located on the right that are able to heal without herniation, diaphragmatic injuries may be herniated due to the difference between intrathoracic and intra-abdominal pressure. The incidence of diaphragmatic injury on the left is greater than that on the right. The main reason for the lower incidence on the right is the protective effect of the liver.

Intercostal herniation may develop post-trauma in association with rib fracture or thoracotomy incision in recurrent diaphragmatic hernias. It is more frequently reported on the left. It may appear in the post-traumatic acute or delayed period. The most common finding is a reducible mass in the thoracic wall.

Twenty to fifty percent of initial radiological examinations in patients developing post-traumatic diaphragm hernias are non-diagnostic. Thanks to modern CT equipment (spiral CT scanners and the latest multilayer CT), the sensitivity of CT has been reported at 61-100%. Small injuries are generally asymptomatic and produce no radiological findings. Murray et al. performed laparoscopy on 57 out of 107 patients with penetrating left thoracoabdominal injury. Using laparoscopy they identified occult injury in 15 (26%) asymptomatic patients. Approaches such as laparoscopy or thoracoscopy are therefore essential in patients who are asymptomatic in the acute post-traumatic period but with suspected clinically diaphragmatic injury (due to the site of the injury) that is undetectable radiologically. The diagnostic efficacy of thoracoscopy in occult injuries is close to 100% in both diaphragm injuries located on the right that are able to heal without herniation. Diaphragmatic injuries may be herniated due to the difference between intrathoracic and intra-abdominal pressure. The visible area in laparoscopy is restricted on the right by the liver. However, laparoscopy does permit examination of both diaphragms and of the abdominal and thoracic cavity (through hernia defect). It also permits the detection of other accompanying intra-abdominal organ injuries. From that perspective, laparoscopy is superior to thoracoscopy, which only permits examination of the thoracic cavity, in acute trauma patients in particular.

Traumatic diaphragmatic hernias must be repaired when they are detected. Isolated diaphragmatic injuries can be repaired safely with both laparoscopy and thoracoscopy. Repair with laparotomy is preferable in the presence of...
accompanying organ injury, however. Due to the adhesions in chronic diaphragmatic hernias, these are repaired with laparotomy or thoracotomy. Recent advances in minimally invasive surgery now make it possible for chronic diaphragmatic hernias also to be repaired with laparoscopy or thoracoscopy. The thoracoscopic approach is difficult in the presence of severe adhesions. It has been reported that repositioning of the herniated organ with laparoscopy is more easily performed than thoracoscopy in such cases. The liver being beneath the right diaphragm makes laparoscopic treatment of injuries in the right posterior diaphragm more difficult. The laparoscopic approach is more reliable in the treatment of injuries of the left hemidiaphragm and right anterior diaphragm. Thoracoscopic, however, is equally effective in both hemidiaphragms.

The number of cases of recurrent diaphragmatic hernias repaired with laparoscopy is limited because of dense postoperative adhesions. The first laparoscopic repair of recurrent chronic traumatic diaphragmatic hernia was reported by Frantzides et al. in 2003. There have been no further case reports on the subject.

Laparoscopic or thoracoscopic repairs can be performed using primary suture, hernia staples or prosthetic material. While primary suturation of small diaphragmatic hernias is recommended, prosthetic material is advised in large defects. Polypropylene mesh should not be used as it may cause digestive fistula. PTFE graft use reduces the risk of digestive fistula. Hernia defect diameter and its relationship with esophageal hiatus are important for the security of the laparoscopic repair in acute or chronic injuries. Matthews et al. recommended open repair for injuries more than 10 cm or with injuries associated with hiatus.

Some publications have reported the development of tension pneumothorax during laparoscopy in patients with diaphragmatic hernia. Gas desufflation and chest tube insertion are therapeutic in such cases. The chest tube must be installed under direct visualization in order to avoid perforation of the herniated organ.

In this case the hernia was located in the left diaphragm, as also reported by Frantzides et al. Adhesions among the omentum, diaphragm and small bowel where the previous repair was performed were released with the help of LigaSure. Herniated organs in the thorax were easily reduced to the abdomen. Since the defect was 9x6 cm in size, repair was performed with dual mesh after primary suturing. No additional procedure was performed for intercostal herniation. No tension pneumothorax developed. No tube thoracostomy was performed during surgery. No recurrence was identified at follow-up at the 22nd month postoperatively.

REFERENCES


INSTRUCTIONS TO AUTHORS

Available at: http://www.scielo.br/revistas/abcd/iinstruc.htm