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C-W Siu, M-H Jim, H-H Ho, F Chu, H-W Chan, C-P Lau and H-F Tse

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Recurrent acute heart failure caused by sliding hiatus hernia

C-W Siu, M-H Jim, H-H Ho, F Chu, H-W Chan, C-P Lau, H-F Tse

The case is reported of a 75 year old woman who presented with recurrent nocturnal episodes of acute pulmonary oedema. The cause was uncertain as she had normal cardiothoracic ratio on chest radiography and normal left ventricular systolic and diastolic function by transthoracic echocardiogram. Another transthoracic echocardiogram was repeated when she was recumbent for an hour and had a full stomach. It showed a striking finding of severe left atrial compression by an external structure. Computed tomography of the thorax showed an intrathoracic mass behind the left atrium causing external compression of the left atrium suggestive of a sliding hiatus hernia. Cardiac catheterisation confirmed the diagnosis by showing a pronounced rise of pulmonary capillary wedge pressure in the recumbent position compared with the sitting up position.

A 75 year old woman presented with recurrent episodes of shortness of breath and chest pain in the previous three months requiring multiple admissions. The diagnosis of acute pulmonary oedema was made but no cause could be found on previous admissions. Her cardiothoracic ratio was normal on chest radiography, her left ventricular function, both systolic and diastolic, were normal by transthoracic echocardiogram. Her symptoms occurred typically at bedtime, especially after a heavy dinner, and were associated with orthopnea, paroxysmal nocturnal dyspnea, and ankle oedema. Physical examination showed regular pulses with a normal blood pressure finding of 124/61 mm Hg. The jugular venous pressure was raised, the heard sounds were normal, and no murmur could be heard. There was bilateral ankle oedema as well as basal crackles heard over both lungs. An electrocardiogram showed normal sinus rhythm without any ischaemic or hypertensive changes. Careful examination of the chest radiograph showed congested lung field with mild bilateral pleural effusion compatible with acute pulmonary oedema. There was also a round shadow behind the heart with an air-fluid level within it. Blood tests including complete blood counts, renal and liver function test, and creatinine kinase activity were within normal limits. Transthoracic echocardiography was repeated when the patient was in the supine position for an hour and had a full stomach. It showed normal left ventricular function but the left atrium was severely compressed by an extrinsic structure confirmed by multiple views (fig 1). Spiral computed tomography of the thorax showed a large hiatus hernia with intrathoracic extension. The hernia was located behind the left atrium causing anterior shift of the heart (fig 2). Subsequently coronary angiography showed normal coronary anatomy. Right heart catheterisation showed that baseline right atrial pressure and pulmonary capillary wedge pressure during prolonged supine positioning were 8 mm Hg and 18 mm Hg respectively. However, after sitting upright for 30 minutes, the right atrial pressure and pulmonary capillary wedge pressure decreased to 5 mm Hg and 6 mm Hg respectively, confirming the diagnosis of significant left atrial compression by the sliding hiatus hernia. She was successfully treated with conservative measures including frequent small meals, avoidance of a late dinner, and sleeping in slanting position using several pillows. She had no further recurrence of acute pulmonary oedema in the subsequent 12 months.

DISCUSSION

Hiatus hernia is a common condition and its incidence increases with age.1 It does not produce symptoms itself in most patients, but may contribute to the pathogenesis of reflux oesophagitis. Infrequently, sliding hiatus hernia may become incarcerated and strangulated, which may subsequently lead to acute chest pain, dysphagia, and a mediastinal mass.2 Furthermore, cardiac compression with haemodynamic collapse has been reported in patients with complicated or large hiatus...
Acute heart failure and sliding hiatus hernia

M Meier, A Woywodt, M M Hoeper, A Schneider, M P Manns, C P Strassburg

Acute liver failure is a rare syndrome with rapid progression and high mortality. It is characterised by the onset of coma and coagulopathy usually within six weeks but can occur up to six months after the onset of illness. Viral hepatitis, idiosyncratic drug induced liver injury, and acetaminophen ingestion are common causes. This report describes the case of a 35 year old man who presented with acute liver failure shortly after binge drinking. Repeated history taking disclosed a gluteal disulfiram implant that the patient had received to treat his alcohol dependence. The patient recovered with maximum supportive care after surgical removal but without liver transplantation. This case illustrates that only meticulous history taking will disclose the sometimes bewildering causes of acute liver failure.

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