

Post-Traumatic Right Diaphragmatic Hernia: A Case Report

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Abstract

Abdominal hernia is a rare consequence of thoraco-abdominal trauma. Herniation of the right side of the diaphragm is an extremely rare condition owing to protection by the liver. Acute presentation is often life-threatening and early diagnosis is critical. Early diagnosis and management of traumatic diaphragmatic hernia (TDH) can be challenging for the emergency department or the trauma surgeon, as these injuries are often clinically masked by other associated severe injuries. We received a patient in the emergency for post-traumatic right diaphragmatic hernia to note that diaphragmatic ruptures (RD) are seen in approximately 5% of severe polytrauma. They remain serious lesions accompanying high morbidity and mortality related to severity of associated lesions. left fractures are the most frequent, on average 75% against 25% on the right.

Keywords: *Post-Traumatic Right; Diaphragmatic Hernia*

Introduction

We received a patient in the emergency for post-traumatic right diaphragmatic hernia to note that diaphragmatic ruptures (RD) are seen in approximately 5% of severe polytrauma. They remain serious lesions accompanying high morbidity and mortality related to severity of associated lesions. left fractures are the most frequent, on average 75% against 25% on the right.

Observation

Patient B N 25 years old with no particular history admitted by the emergency setting for chest pain with dyspnea in a febrile context T ° 38.5 following an abdominal trauma. The physical examination does not find any sign of semiological value. Seen the dyspnea and chest pain such a frontal thorax was performed.



Figure 1: *Opacity of Hydroaeric Tone Occupying the Entire Right Hemithorax.*

A thoracoabdominal CT scan was performed.

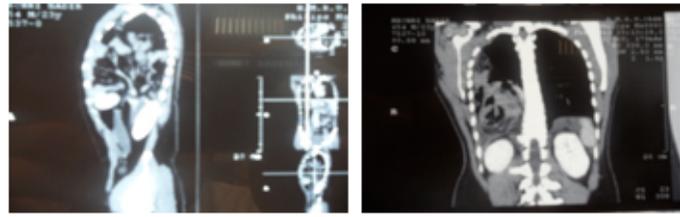


Figure 2: Right Diaphragmatic Hernia by Rupture of the Diaphragm by the Presence of Digestive Loops in the Right Thorax with their Vascular Pedicle Intrathoracic.

The biological assessment shows a hyperleukocytosis, the rest of the assessment is correct.

Patient admitted to the operating room urgently due to the noisy symptoms and the risk of intrathoracic small bowel volvulus.

Admission to the operating room: Left lateral decubitus position Right thoracotomy incision on the right 6th intercostal space. Exploration finds lensensble of the small intestine in the thorax, release and introduction of the small intestine into the abdomen. Closure of the diaphragmatic breach by placing a prosthesis. fermeture of the thorax on a thoracic drain.

The evolution

patient discharged in the 6th postoperative day after removal of the chest tube. Such a frontal thorax has been produced which aims: a return to the wall of the right lung.



Figure 3: Such Frontal Thorax after Ablation of the Drain.

Discussion

Despite advances in medical imaging, the diagnosis R and D is performed in the preoperative period in only 40 to 70% of cases [1]. A simple chest x-ray of the front and side can sometimes confirm the diagnosis, especially in the left locations, A right most often it all comes down to a simple ascent of the diaphragmatic dome. In these more difficult cases, the chest scanner is very useful especially as this is a requested routine examination admission of the patient to the emergency room [2,3].

Conclusion

Posttraumatic diaphragmatic hernias are rare pathologies but can have a poor prognosis if they are not treated in time, namely surgical complications, namely strangulation, perforation.

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