Please Read Carefully !!
A Case Presentation

Amir Morgan
Consultant Colorectal
Ipswich Hospital

Case Summery

- A 33 Y , Male
- Very Fit & Healthy
- Practice Water Sports, Jogging, Football
- Got Admitted to NNUH in 3 different occasions:
  - Once Elective &
  - Twice for emergency Reasons

ADDRESS FOR REPORT: GASTRO UNIT

HISTOPATHOLOGY REPORT

LAB No: 06S25846
CAT

CASE HISTORY:
Iron deficiency anaemia. 1 cm caecal polyp at ileocaecal valve. ? adenomatous.

MACROSCOPIC:
Cellsafe.

MICROSCOPY:
Large intestinal mucosal biopsies showing elongated crypts and fairly diffuse moderate to severe lamina propria chronic inflammation. No crypt abscess or granuloma formation is recognised. There is no evidence of dysplasia or malignancy.

DIAGNOSIS:
CAECAL POLYP BIOPSIES.

REPORTED BY:
Dr. V. R. Sams, Consultant Histopathologist.

REPORT DATE:
13.07.2006

HISTOPATHOLOGY REPORT

LAB No: 07S06915
MN

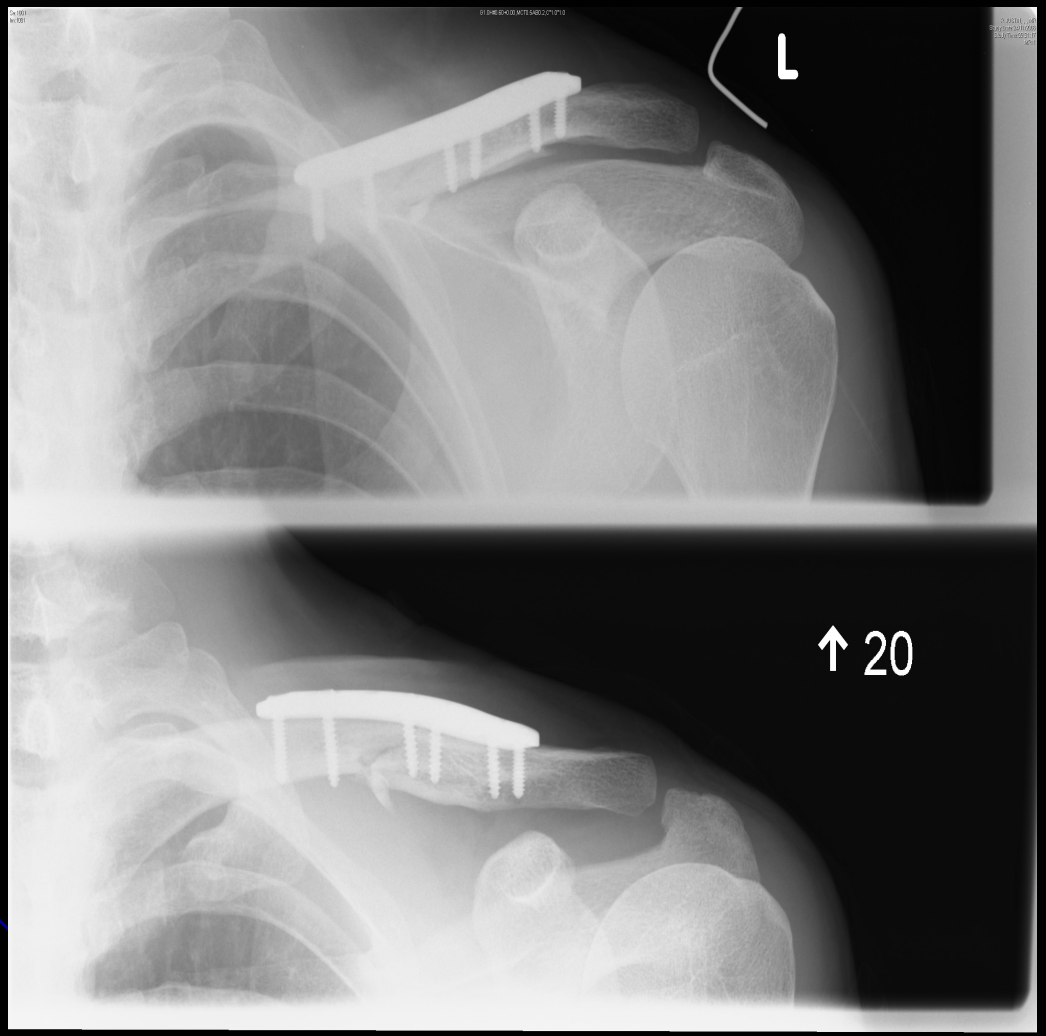
07 MAR 2007

CASE HISTORY:
Anaemia. Investigation: abnormality at ileocaecal valve on colonoscopy. Capsule enteroscopy revealed ? angiodysplasia. Operation findings -?Crohn's. Three strictures identified in terminal ileum. Ileocaecal resection.

MACROSCOPIC:
Ileocaecal resection the ileum of which measures 21 cm and the included colon of which measures 6 cm in length. The serosal surface of the ileum shows focal fat wrapping. On opening the ileum three strictures are seen; the most prominent 2 cm from the ileal resection margin. The second stricture is located 4 cm distal to the first area, and the third stricture is located 3 cm distal to the second area.
A = the most proximal stricture including part of the proximal resection margin. B = area between first and second stricture. C = second stricture. D = area between 2nd and 3rd stricture. E & F = 3rd stricture. G = appendix. H = caecum. I & J = mesenteric nodes. CP/SJD

MICROSCOPY:
The areas of ileal stricture show acute ulceration with associated acute and chronic transmural inflammation with submucosal, intramuscular and subserosal granulomatous inflammation and insipient fissuring type ulceration (E). No dysplasia or malignancy is seen. There is distorted but probable serosal granulomatous inflammation at the ileal surgical margin (A) along with focally active mucosal inflammation at this level also. Serosal granulomas are also seen on the surface of the sampled unstrictured bowel (B).
The sampled large bowel shows submucosal lymphoid aggregates with loose granulomas within them. However, no acute ulceration is seen.
The appendix shows focally active chronic inflammation but no unequi[illegible] granulomas are recognised.
The mesenteric lymph nodes show granulomatous inflam[illegible] with loose epithelioid cell granulomas.

DIAGNOSIS:
ILEOCAECAL RESECTION: CROHN'S DISEASE (SEE ABOVE).


L
20

CULT	ALC	ABG	Other	Saved in A&E

Urine: LEU	NIT	PRO	pH	BLD	KET	GLUC	Preg Test	MSU sent
- ve	- ve	+	6.	Neg	+2			

XRAY Site:	CT Site:

Social: Independent Lives Alone	With Spouse/ Partner/ Family	Nursing/Residential Home	Sheltered/Warden Home with Care

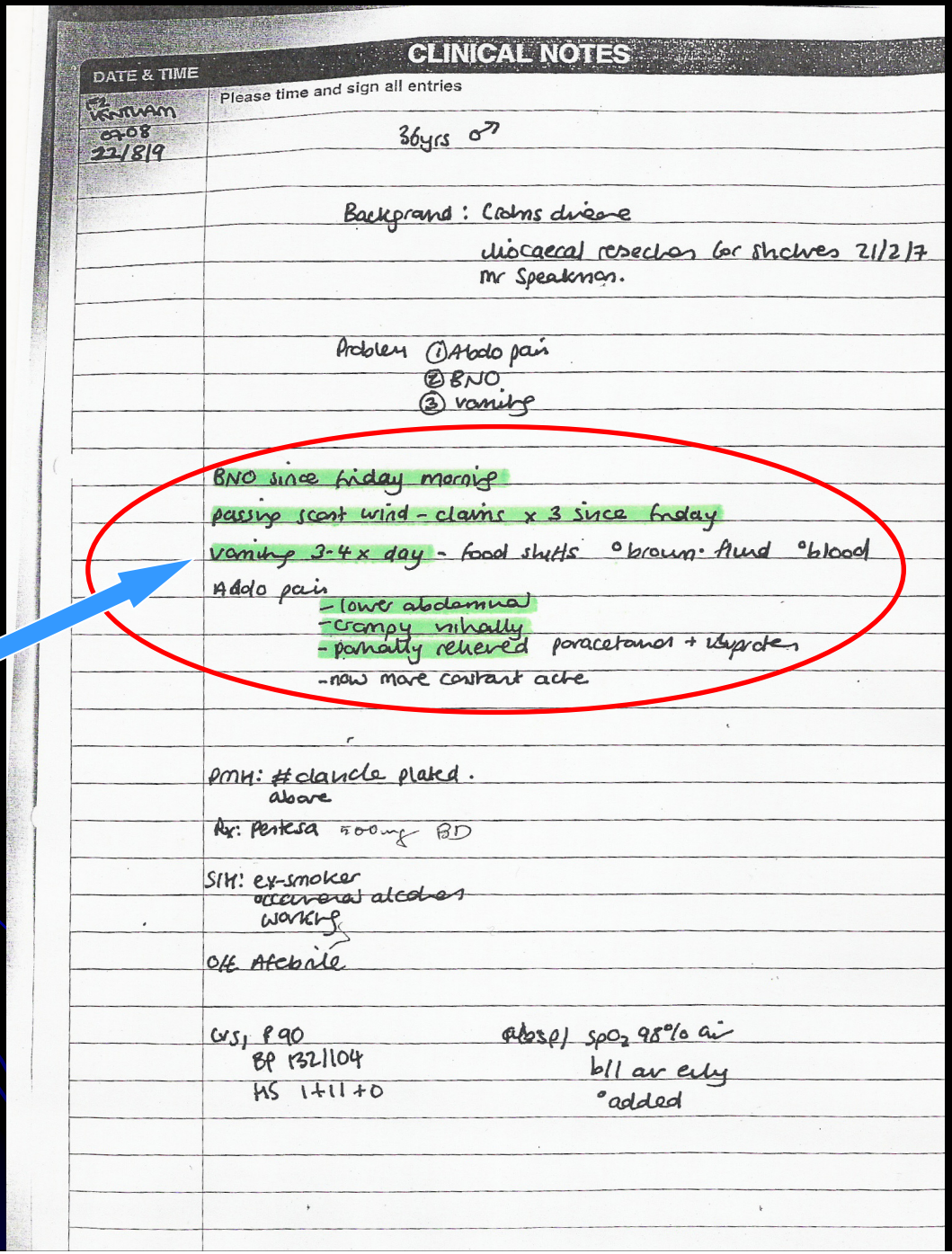
Home Care x per day x per week	Mobility: Independent Sticks Frame Immobile

Other Social Care e.g. CPN, Social Worker, Other

Property: Kept by Patient Bagged & Labelled	Given to Relative (Signature of Relative)	Hospital Safe Property Book No	Valuables Left on Deceased Patient (list)

Medications with Patient for Transfer to Ward/Discharge? Yes No

Date & Time	Medical/Nursing Notes Please sign, date and time ALL entries
11/8/09 06.10- (Tuesday)	CA, c/o abdo pain known Crohns disease Went body surfing on friday and afterwards began having pain in upper abdomen and has not had bowels open since. - Saw Dr in A+E in minehead, given analgesia and told nothing acute. - Pain ↑ tonight has still not had bowels open - very concerned. CA Gilman



CLINICAL NOTES

DATE & TIME

Please time and sign all entries

Dr Kannam
0708
22/8/19

36yrs ♂

Background : Crohns disease
ileocaecal resection for strictures 21/2/17
Mr Speakman.

Problem ① Abdo pain
② BNO
③ vomiting

BNO since friday morning
passing scant wind - claims x 3 since friday
vomiting 3-4 x day - food shifts °brown °fluid °blood
Abdo pain
- lower abdominal
- crampy initially
- partially relieved paracetamol + ibuprofen
- now more constant ache

PMH: #clavicle plated.
above

Rx: Pentasa 500mg BD

SH: ex-smoker
occasional alcohol
working
Off Aftcbile

CVS, P 90
BP 132/104
HS 1+11+0

Resp, SpO_2 98% on air
b/l air entry
°added

AFFIX PROFORMA HERE IF REQUIRED

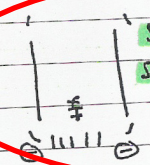
DATE & TIME

CLINICAL NOTES

Please time and sign all entries

F2 VENTHAM

abdo



Slightly distended
same layer abdo tenderness
guarding / rebound
BS present.

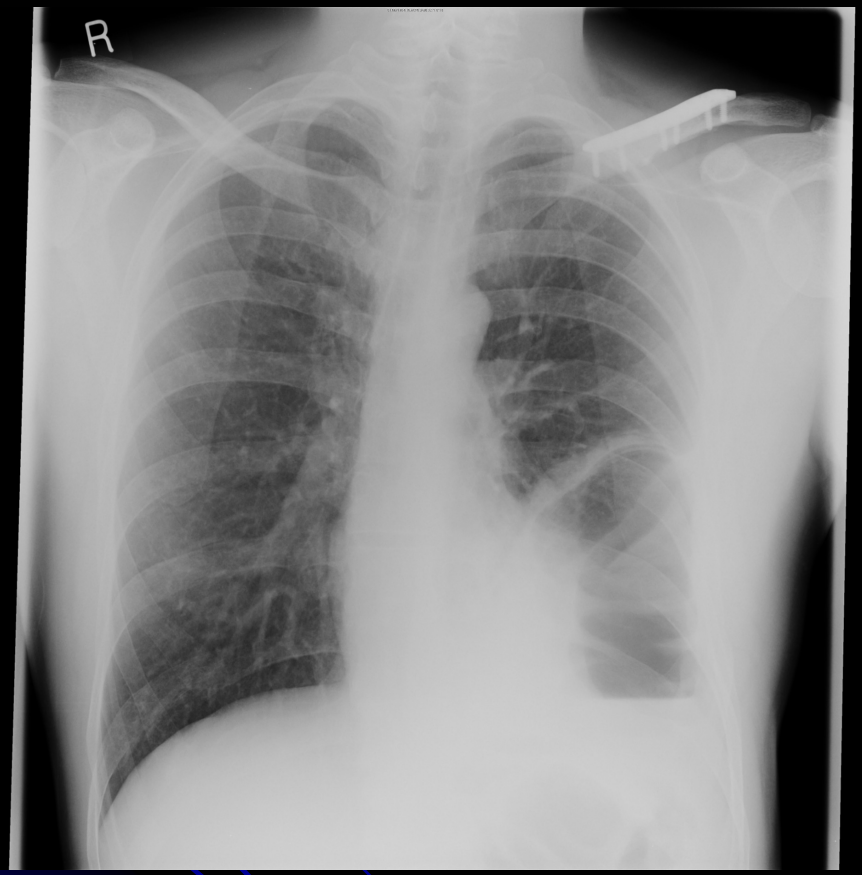
PR exam
- verbal consent
- no ext. abscess / fistula
- mucus on glove +
- no blood no blood.
- empty rectum

AXR dilated transverse colon
stool in descending colon.

1) check bloods / inform makes.
2) referred surgeon 0745 MEa.

? Shadow
? adhesions

WCC 13.5
Hb 17.7
Plts 276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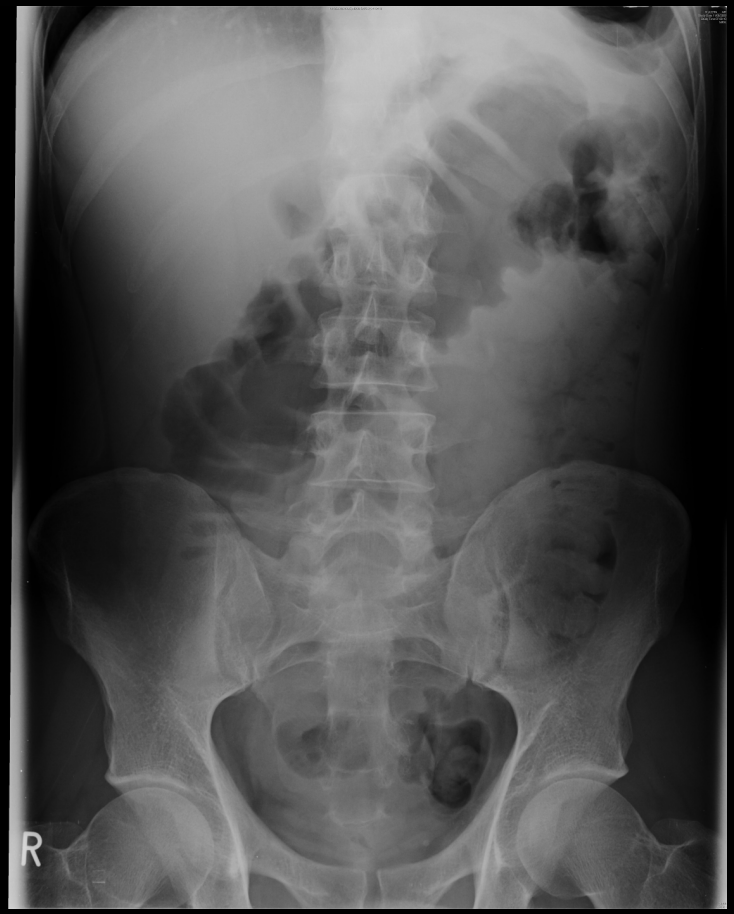

R

D

R[redacted], Justin | Male | Reg. No.

Hospital Number: 0674879 | NHS Number: 428 931 7731 | Sheet

Date of Birth: Minehead A+E referral (on SATURDAY), self referral.

11/05/09

09:30am

36, Maintenance Engineer

Crohn's Disease
SB resection – Mr Spreadmar 2007.

PC: abdominal pain

HPC: – 5/7 hx of acute crampy abdo pain, severity (8/10), no radiation
– Loss of appetite, Last night Sun evening
– Some relief of pain with pain killers
– Vomiting – Saturday, several times, no blood
– Intermittent pains (few secs); but come up v. frequently
– Now constant pain since yesterday pm
– Bowels not opened since Friday morning.
– Normally BOWELS regular opening (1-2)
– Passed wind (x3 since Friday).
– No chills, fever, shakes.

PMH: Crohn's Disease 2006 Dx
Small Resection 250ml 2007 Dx.
Follow up (once a year)
(L) shoulder pain – due to plate a previous RTA has had plate.

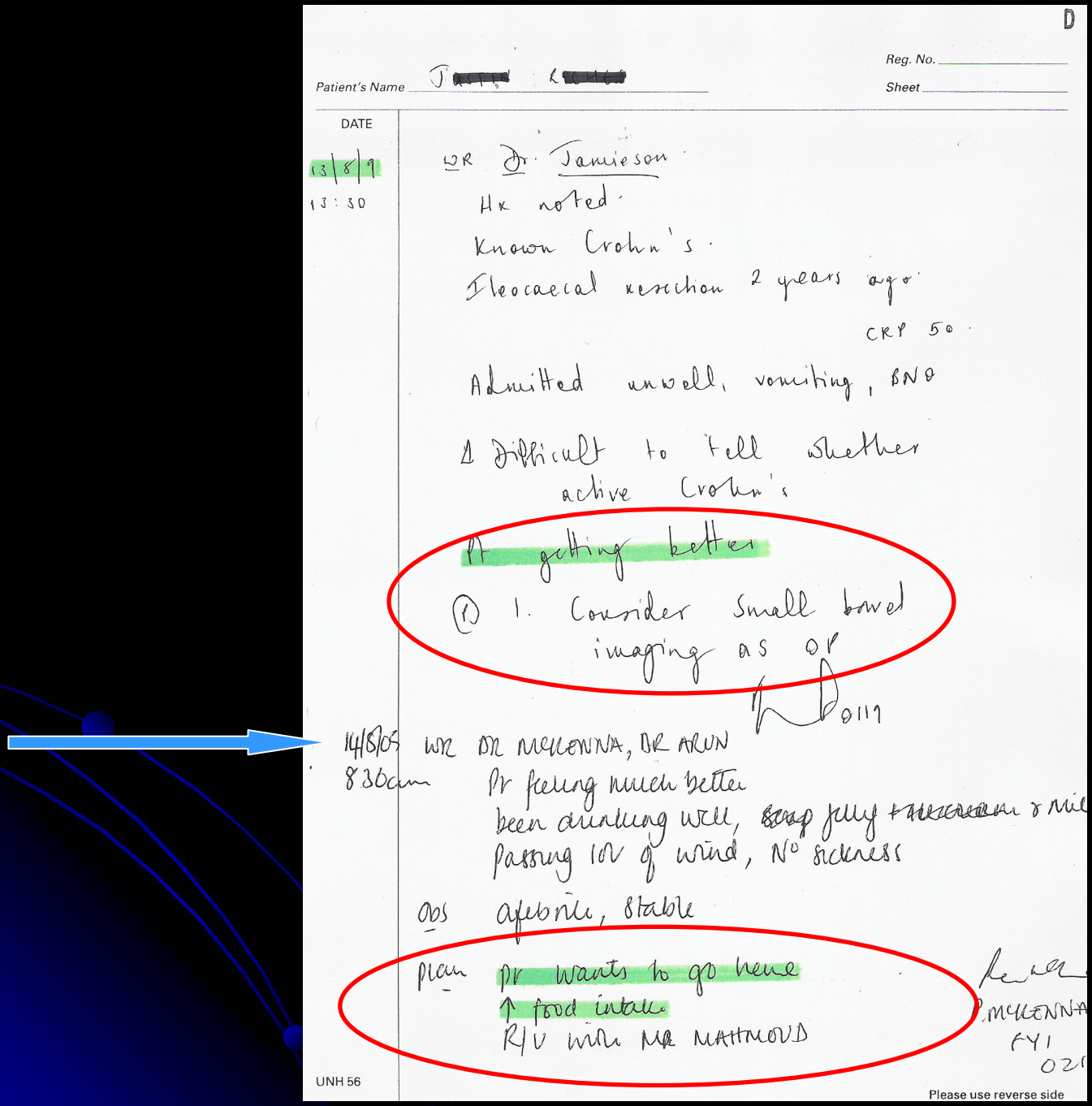
No other medical problems

Meds: Pentasa 500mg (2 @ night, 2 @ morning)
NKDA.

SH: non smoker
occasional drinker

UNH 56

Please use reverse side



D

Patient's Name [redacted]

Reg. No.

Sheet

DATE

13/8/9

13:30

WR Dr. Jamieson

Hx noted.

Known Crohn's.

Ileocaecal resection 2 years ago.

CRP 50.

Admitted unwell, vomiting, BNO

Δ Difficult to tell whether active Crohn's

Pt getting better

(1) 1. Consider small bowel imaging as OP

0117

14/8/09 WR DR MCKENNA, DR ARUN

8.30am Pt feeling much better

been drinking well, soup jelly [illegible]

passing lots of wind, No sickness

O/E afebrile, stable

Plan Pt wants to go home

↑ food intake

R/V with MR MAHMOUD

D. MCKENNA

FYI

02

UNH 56

Please use reverse side

DATE & TIME | **CLINICAL NOTES**

Please time and sign all entries

9/9
10.40
15/8/9

MRS Mitchell, AHE ...

PC/HPC

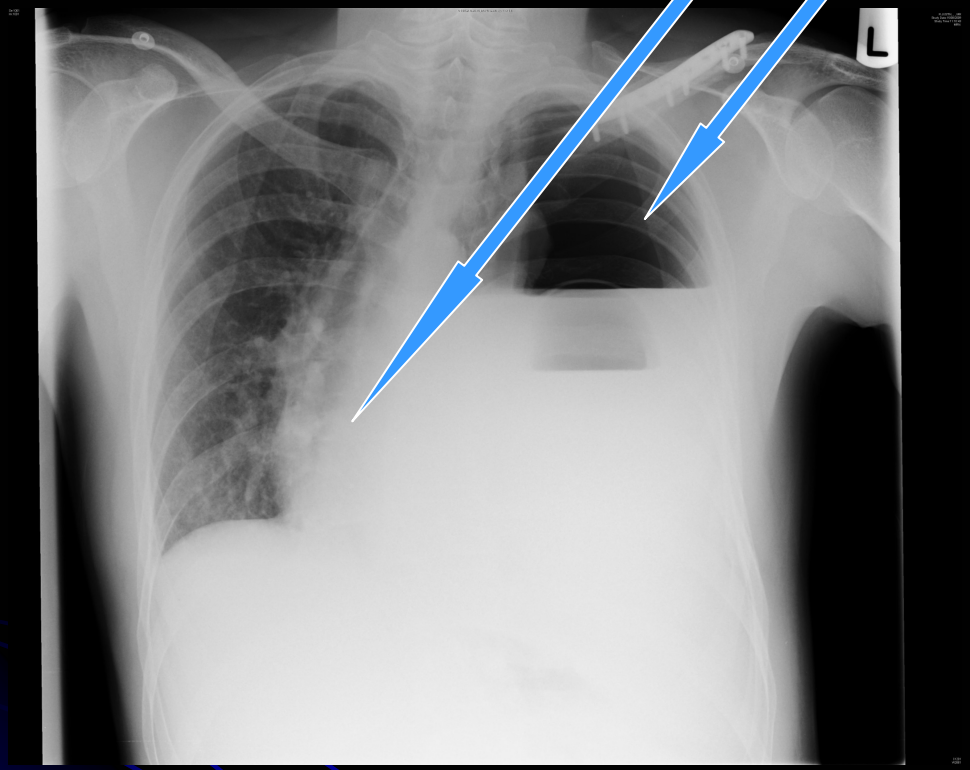
Chronic Crohn's disease pt, previous years, admitted Tue 11/8/9 – Friday 14/8/9 last week with subacute SBO, treated conservatively c̄ NG tube + NBM. Settled after 2/7, now passing wind + bowels opened × 2 since restarted. D/C yesterday.

Yesterday pm, feeling a little tight chest, odd feeling (L) chest. O/N became increasingly SOB. No true chest pain, but (L) chest discomfort + tight chested. Never had this before. Not like childhood asthma. O2 has helped a little, but still v. SOB, + worse only lying down.

PMH
Childhood asthma now resolved
Crohn's disease – not active
°DM °MI °Epilepsy °Asthma now

Drugs nil
Allergies nil known

O/E SOB at rest, sitting bolt upright.
v poor air entry (L) base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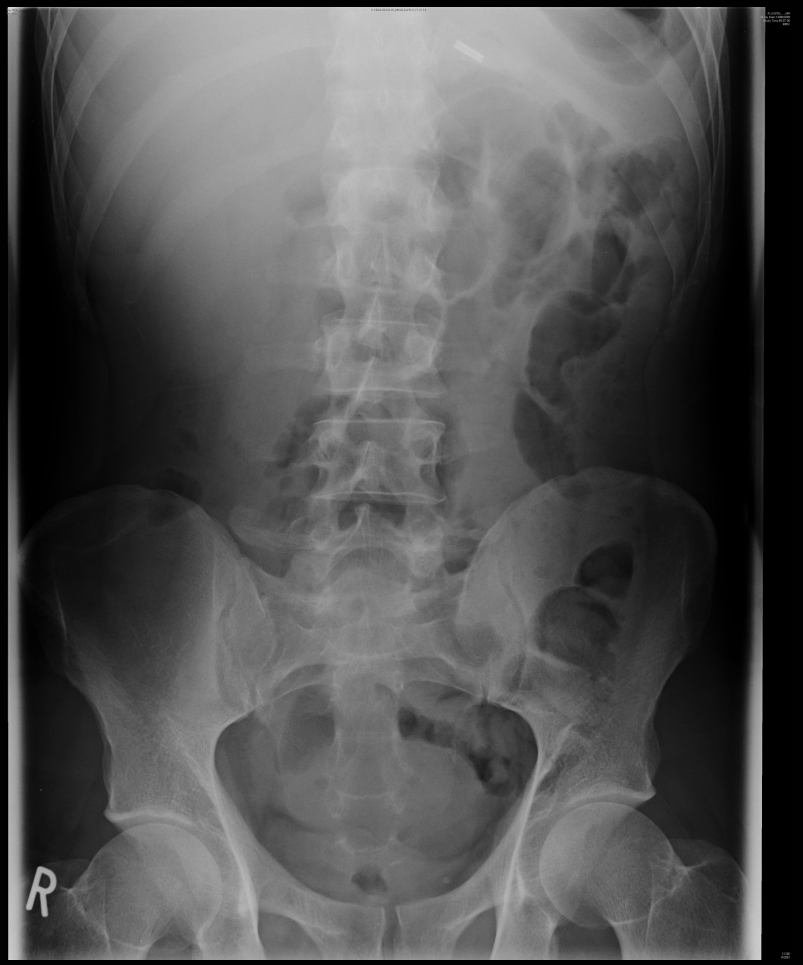
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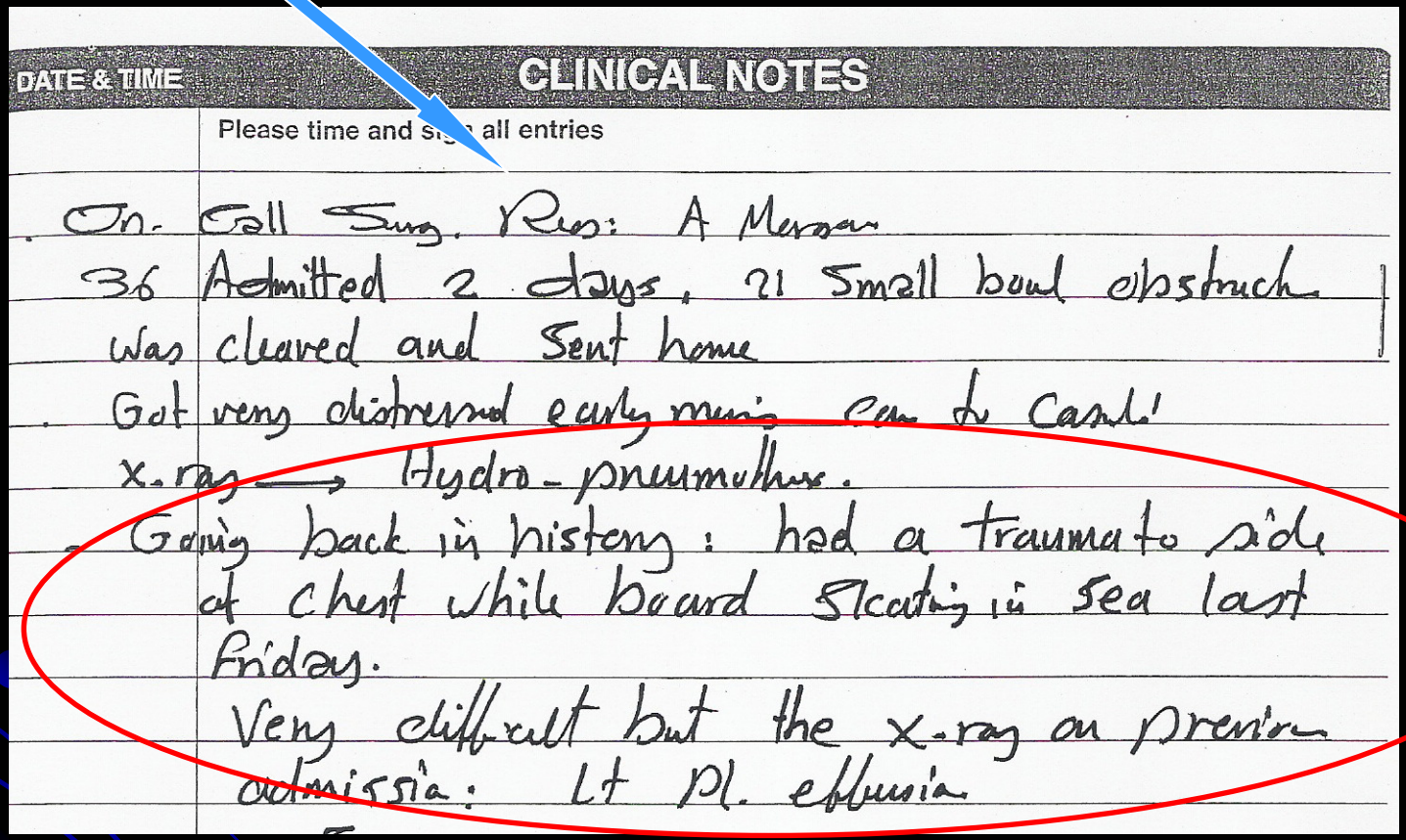


DATE & TIME | CLINICAL NOTES

Please time and sign all entries

On Call Surg. Res: A Mersan

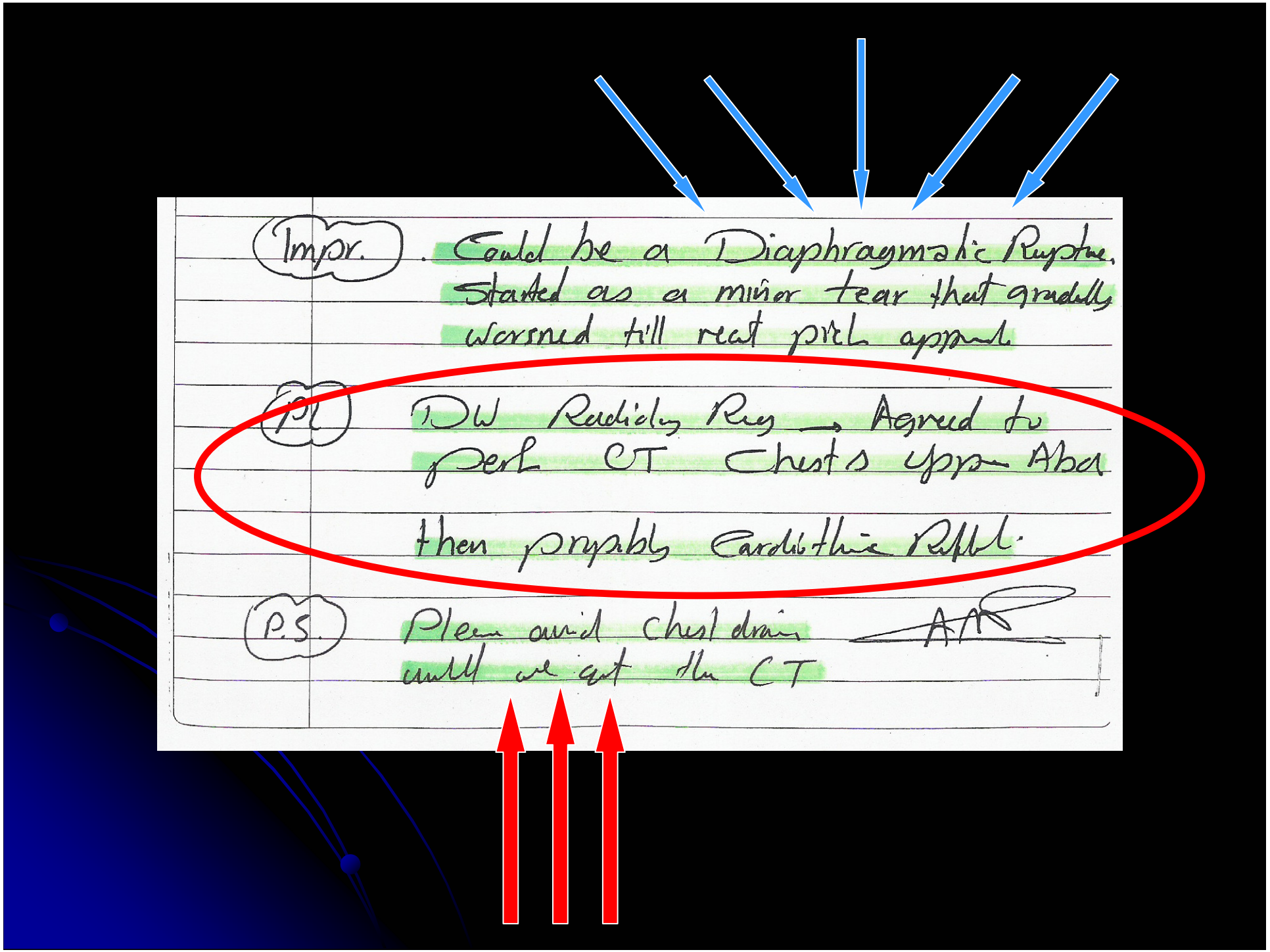
36 Admitted 2 days. 2/1 Small bowel obstruction was cleared and sent home

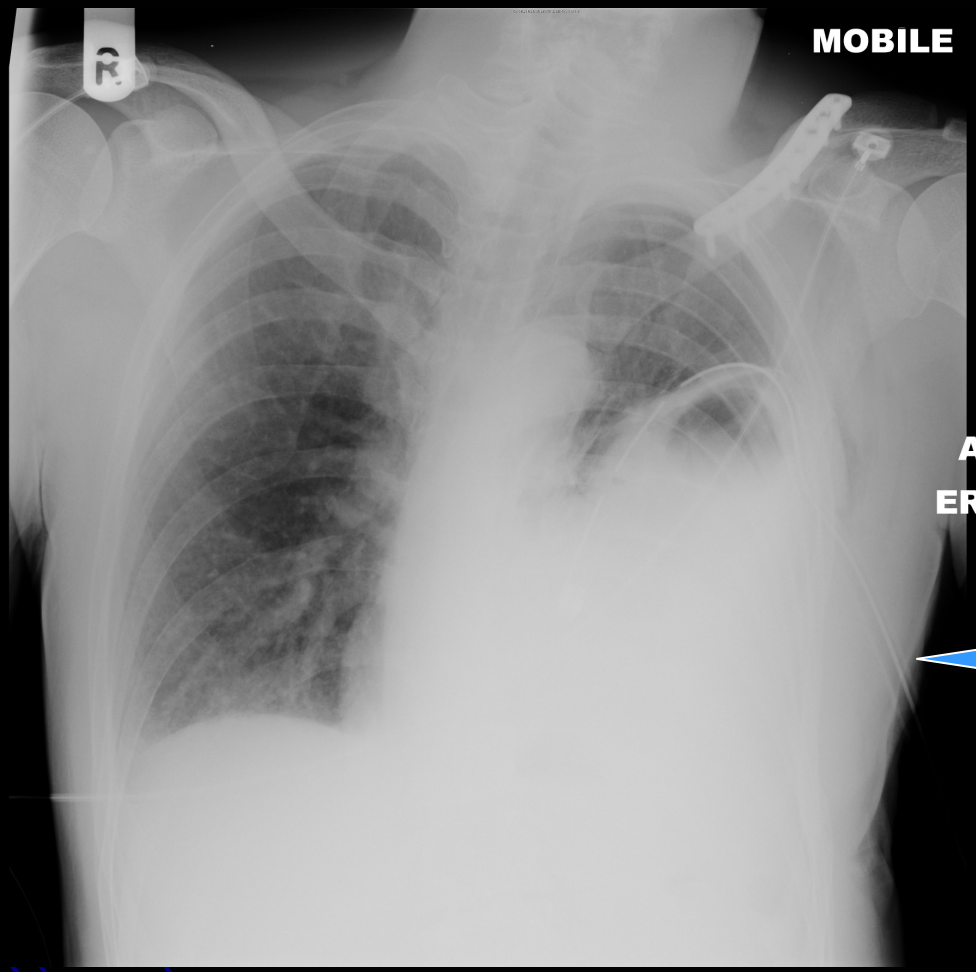
Got very distressed early morning can be Cardiac

x-ray → Hydro-pneumothorax.

Going back in history: had a trauma to side of chest while board skating in sea last Friday.

Very difficult but the x-ray on previous admission: Lt Pl. effusion


Impr.
Could be a Diaphragmatic Rupture.
Started as a minor tear that gradually
worsened till recent pt. appt.
Pl
DW Radiology Rep → Agreed to
perf CT Chest & upper Abd
then probably Cardiothoracic Rsltt.
P.S.
Pleas avoid chest drain
until we get the CT


MOBILE
AP
ERECT

CT Chest 15.08.09

Findings: there is the chest drain on the LEFT chest. There is now minimal pleural gas and the fluid in the pleural space has largely been drained. There there is subcutaneous emphysema. there is consolidation and largely collapse of the LEFT lower lobe. There is some consolidation and collapse of the LEFT lower lobe. There is evidence of diagramatic rupture with a loop of dilated splenic flexure passing into the hernia. There is some thickening of the bowel wall. No other bowel is seen within the hernia. There is no dilated bowel within the abdomen. There is a little fluid in the pelvis. There are some small bowel sutures in the RIGHT iliac fossa which reflect, I understand, a history of Crohn's disease. No bony injury is seen. The liver, spleen, kidneys, pancreas and adrenal glands are unremarkable.

Conclusion: the appearances are consistent with a loop of splenic flexure within an LEFT diaphragmatic hernia with thickening of the bowel wall.

Report Author : PNM, DR P MALCOLM

Creation Date : 2009.08.15
Creation Time : 14:01:38.0000

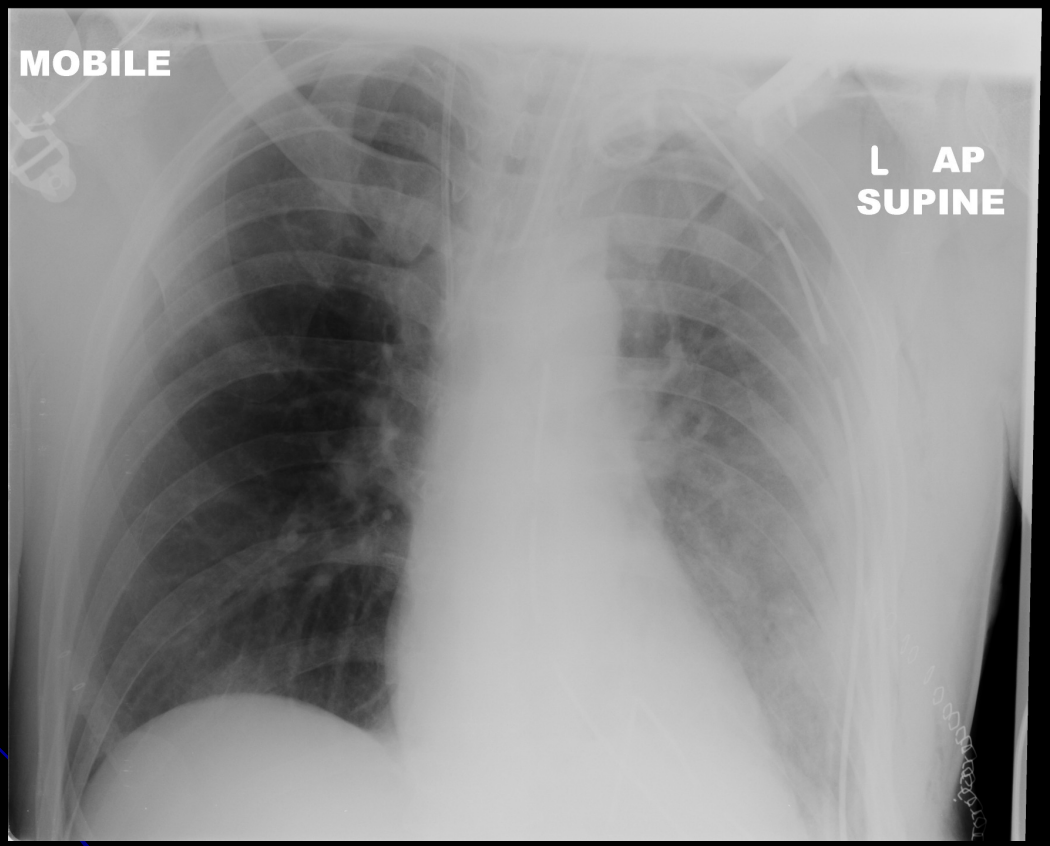
Approved by : PNM, DR P MALCOLM

Approval Date : 2009.08.15
Approval Time : 15:47:00.0000

THIS REPORT WAS RECEIVED FROM TC-Rad RIS System

==========REPC

Patient Name : R[redacted], J[redacted] MR
Patient ID : 0674879
Birth Date : 1973.02.17


MOBILE
L AP
SUPINE

DATE

24/08

8am

WR SpR Hindmarsh

Pt well. Drains out.
Obs stable, apyrexial.
Abdo wound clean.

P 1) If < 500ml in stoma, pt can go home.

2) Abdo sutures out 25/08

JUSTIN RICHES QISS

U+E

Na 136
K 4.3
U 2.8
Cr 54

LFB (↔)

Bil 5
Alb 17
Glob 36
Prot 52
ALT 27.

CRP 201 (↔)

ALP 106
GGT 84

FBC 22/

WCC 13.7 ?
Neut 12.11 (↑)
Plt 571
Hb 10.7

0205 (02)

20/08/09

7 55

WR Mr Hindmarsh

Patient well

Stoma: 505
Obs stable
Apyrexial

Plan:

1) Remove stitches / staples
2) Home
3) R/V in clinic in 6-8/52

VANNATHE (FY)

Have a Look at that :

Radiological Report : Clinical Information:

Acute abdominal pain, chrons disease, small bowel resection

Any signs of perforation

Report:

Repored with Dr. S Williams (Consultant Radiologist)

Lungs and pleural spaces clear. Elevated contour of the left hemidiaphragm and splenic flexure of the colon. This is new relative to the CT fo 2006. Note of a left clavicular fracture (Oct 2008) and a subsequent vertebral compression fracture in Feb 2009. Did the patient have significant trauma at htat time? This could represent a diaphragmatic rupture or paralysis.

Report Author : SDR, DR SHEVANTHA DILSHAN ROSA

Creation Date : 2009.08.14
Creation Time : 11:40:31.0000

Approved by : SDR, DR SHEVANTHA DILSHAN ROS

Approval Date : 2009.08.14
Approval Time : 14:46:00.0000

THIS REPORT WAS RECEIVED FROM TC-Rad RIS System

Lessons To Learn

- Take a **good History**
- **Read** Old Notes Carefully
- **Communicate** with other members of Team. especially Radiology Teams
- **Do not** request investigations then forget about it
- Discuss with **senior team** the discharge plans
- **Consider** all aspects of management
- **Always Record** your Name & Time of review clearly

Diaphragmatic Hernia

- 2 categories:
  - Congenital:
    - Embryologic defects in the diaphragm
    - Present early rather than late in life
    - However, a subset of adults may present with a congenital hernia that was undetected during childhood
  - Acquired:
    - All types of trauma,
    - With blunt forces accounting for the majority.

History of Procedure

- The first traumatic diaphragmatic hernia was reported by Sennertus in 1541
- The first two deaths were described by Ambrose Paré in 1578, one from strangulated bowel.

- Blaivas M, Brannam L, Hawkins M, Lyon M, Sriram K. Bedside emergency ultrasonographic diagnosis of diaphragmatic rupture in blunt abdominal trauma. *Am J Emerg Med*. Nov 2004;22(7):601-4. [Medline]

Problem

- Require a high level of suspicion to detect
- Patients can be asymptomatic :
  - 53% of hernias from blunt trauma
  - 44% from penetrating trauma
- Routine chest x-ray detects only **33%** of hernias when interpreted by the trauma team leader at initial evaluation
- Missed injuries are associated with **significant morbidity and mortality.**

- Hanna WC, Ferri LE, Fata P, Razek T, Mulder DS. The current status of traumatic diaphragmatic injury: lessons learned from 105 patients over 13 years. *Ann Thorac Surg*. Mar 2008;85(3):1044-1048. [Medline]

Frequency

- Of patients admitted to the hospital for trauma, **3-5%** have a diaphragmatic hernia
- The male-to-female ratio is **4:1**
- Most presenting in the **third** decade of life
- Approximately **0.8-1.6%** of patients with blunt trauma sustain a rupture of the diaphragm
- Approximately:
  - **69%** of hernias are left-sided,
  - **24%** are right-sided, [Hepatic protection]
  - **15%** are bilateral
  - Children have **equal rates** of rupture per side, likely due to laxity of liver attachments

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- Turhan K, Makay O, Cakan A, Samancilar O, Firat O, Icoz G, et al. Traumatic diaphragmatic rupture: look to see. *Eur J Cardiothorac Surg*. Jun 2008;33(6):1082-5. [Medline]
- Cameron JL. Diaphragmatic injury. In: *Current Surgical Therapy*. 9th ed. Philadelphia, PA: Mosby-Elsevier; 2008:975-987
- Mansour KA. Trauma to the diaphragm. *Chest Surg Clin N Am*. May 1997;7(2):373-83. [Medline].

Presentation

- **Clinical findings include:**
  1. Marked **respiratory distress**,
  2. **Decreased breath sounds** on the affected side,
  3. **Palpation of abdominal contents upon insertion of a chest tube,**
  4. Auscultation of **bowel sounds** in the chest
  5. **Paradoxical movement** of the abdomen with breathing
  6. Diffuse abdominal pain.

Etiology

- most common is either:
  - Blunt:
    - Motor vehicle accidents are the leading cause
  - Penetrating:
    - Gunshot or stab wounds
- Other rare causes include:
  - Labor in women with prior diaphragmatic hernia repair
  - Barotrauma during underwater dives in patients with history of Nissen fundoplications

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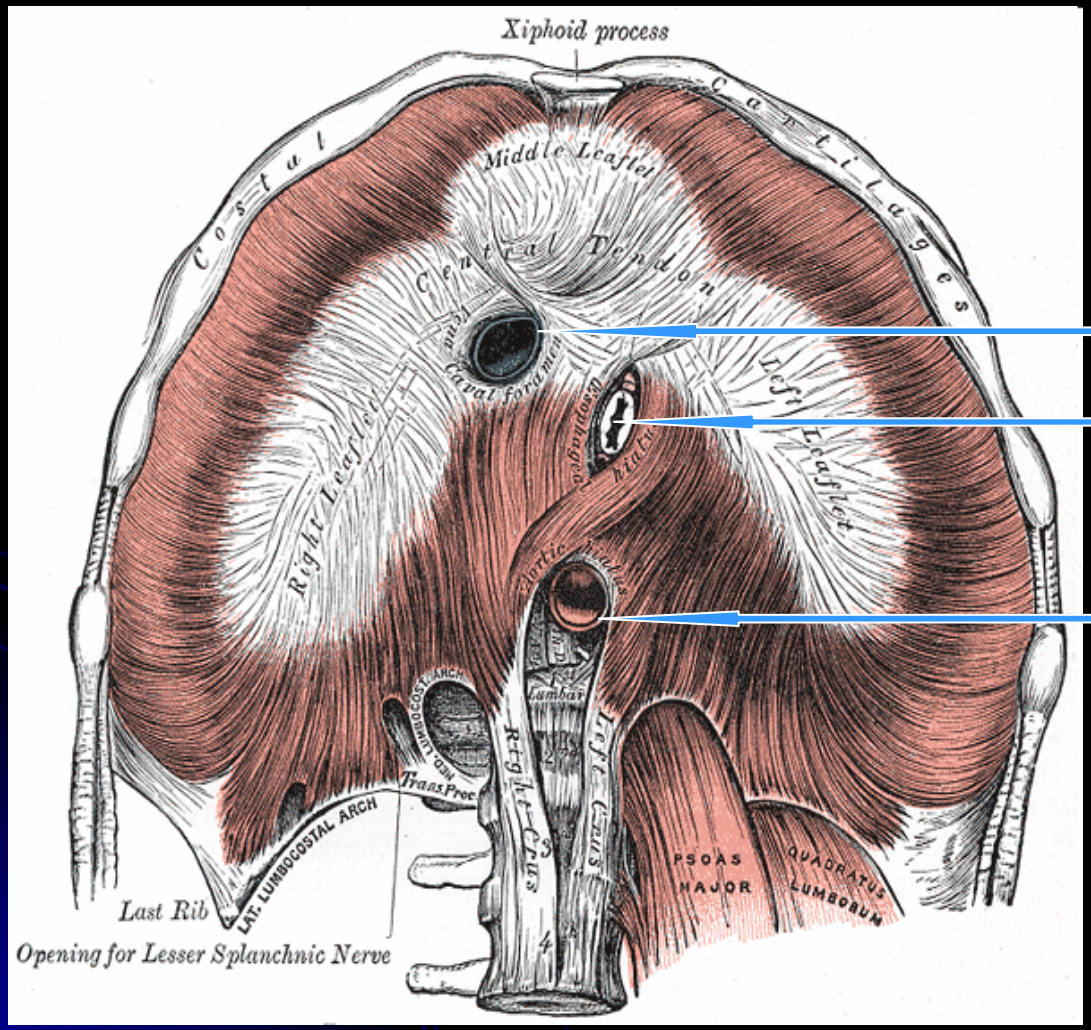
- Hamoudi D, Bouderka MA, Benissa N, Harti A. Diaphragmatic rupture during labor. *Int J Obstet Anesth*. Oct 2004;13(4):284-6. [Medline].
- Hayden JD, Davies JB, Martin IG. Diaphragmatic rupture resulting from gastrointestinal barotrauma in a scuba diver. *Br J Sports Med*. Mar 1998;32(1):75-6. [Medline].

Relevant Anatomy

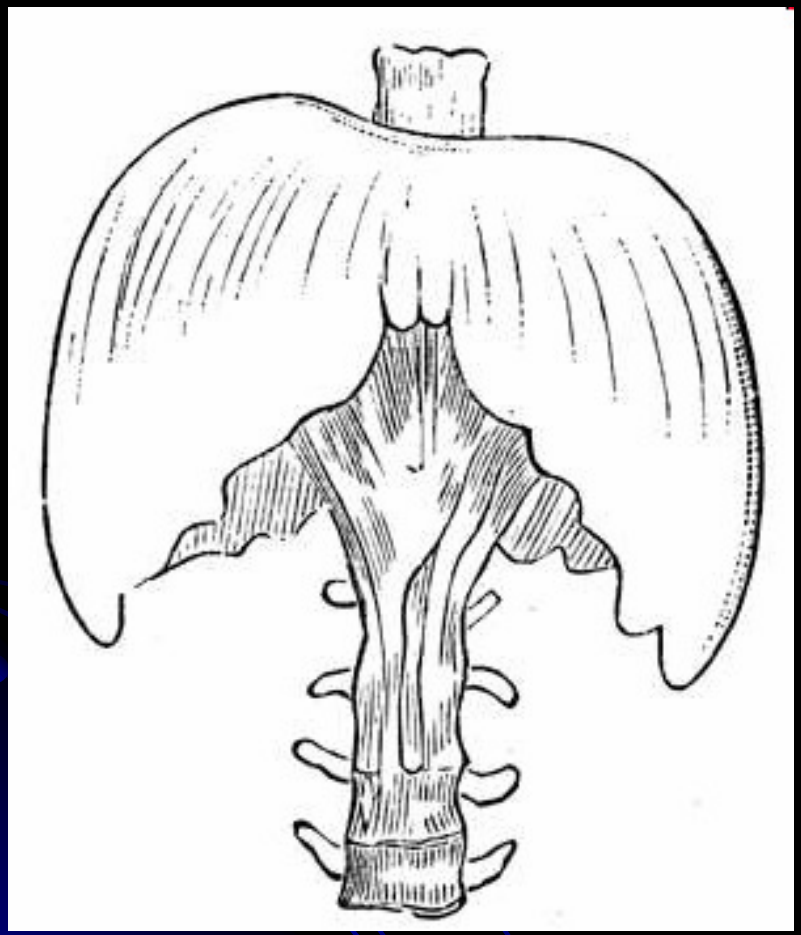


IVC Opening : T8/T9 Disk

Hiatus: T10

Aortic Opening: T12

- Aorta
- Thoracic Duct
- Azygos / Hemiazygos V



Arteria Supply :

- Right and left Phrenic arteries
- The Intercostal arteries,
- Musculophrenic branches of the Internal thoracic arteries
- Small branches of the Pericardiophrenic arteries

Venous Drainage :

- Rt. : Inferior vena cava and Azygous vein
- Lt. : Adrenal / Renal & Hemizygous

Nerve Supply: Phrenic nerve

- Remember that **"C3, C4, and C5 keep the diaphragm alive."**
- Originating around the level of the **Scalenus anterior** muscle

Contraindications

- Relatively **no contraindications** have been reported for repair of an acquired diaphragmatic hernia
- Many small injuries are **discovered during** exploratory laparotomy for the repair of other intra-abdominal injuries.
- Diaphragmatic hernias **should always be repaired**. Lack of repair of a diaphragmatic hernia can lead to incarceration and strangulation of intra-abdominal contents or respiratory dysfunction.

Imaging Studies

- **Chest radiography** is standard in the advanced trauma life support (ATLS) protocol for a trauma workup :
  - **23-73%** of traumatic diaphragmatic ruptures will be detected by **initial** chest radiograph
  - additional **25%** found with subsequent films
  - Abdominal contents in the thorax, with or without signs of focal constriction **("collar sign“)**
  - Nasogastric tube seen in the thorax
  - Elevated hemidiaphragm (**>4 cm** higher on left vs right)
  - Distortion of diaphragmatic margin

- Sliker CW. Imaging of diaphragm injuries. *Radiol Clin North Am*. Mar 2006;44(2):199-211, vii. [Medline].

- **CT scan**
  - **Conventional**
    - Sensitivity of 14-82%, with a
    - Specificity of 87%.
  - **Helical CT** increased
    - Sensitivity 71-100%, with higher sensitivity left vs right.
  - **CT findings indicating rupture include the following:**
    - Direct visualization of injury
    - Segmental diaphragm nonvisualization
    - Intrathoracic herniation of viscera
    - "Collar sign"
    - Peridiaphragmatic active contrast extravasation

- **Ultrasonography (focused assessment with sonography for trauma [FAST] scan)** has been reported to detect diaphragmatic hernias.
  - Movement, Through visualization of each upper quadrants
  - This technique is limited in some patients

- Blaivas M, Brannam L, Hawkins M, Lyon M, Sriram K. Bedside emergency ultrasonographic diagnosis of diaphragmatic rupture in blunt abdominal trauma. *Am J Emerg Med*. Nov 2004;22(7):601-4. [Medline].

Surgical Therapy

- If the diaphragmatic injury is discovered during the **acute phase of trauma**, the standard surgical approach is laparotomy or, less commonly, thoracotomy

- When the diaphragmatic injury is **unnoticed for months or years**. More surgeons approach long-standing hernias with a transthoracic or thoracoabdominal approach because the herniated intra-abdominal contents tend to be firmly attached to intrathoracic structures, making a transabdominal approach difficult.

- **Laparoscopic abdominal exploration** in the setting of trauma is becoming a popular way to determine if diaphragmatic integrity is retained. It provides a minimally invasive mechanism to directly view the diaphragm to determine if an injury has occurred. In the absence of other intra-abdominal injuries, the diaphragm can easily be repaired by applying laparoscopic techniques

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- Hanna WC, Ferri LE, Fata P, Razek T, Mulder DS. The current status of traumatic diaphragmatic injury: lessons learned from 105 patients over 13 years. *Ann Thorac Surg*. Mar 2008;85(3):1044-1048. [Medline].

- Repair:
  - **Acute** injuries : monofilament permanent sutures
  - **Small lacerations** : interrupted, horizontal mattress, or figure-of-eight stitches
  - **larger lacerations** continuous or double-layered closures.

Absorbable sutures are associated with a high rate of recurrence

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- Turhan K, Makay O, Cakan A, Samancilar O, Firat O, Icoz G, et al. Traumatic diaphragmatic rupture: look to see. *Eur J Cardiothorac Surg*. Jun 2008;33(6):1082-5. [Medline].

Follow-up

- **Periodic assessments** of pulmonary function and chest radiography are important
- **Spontaneous recurrence rate** for repaired diaphragmatic hernias is low,
- **Small defects in the repair** site have been reported; therefore, surveillance is crucial.

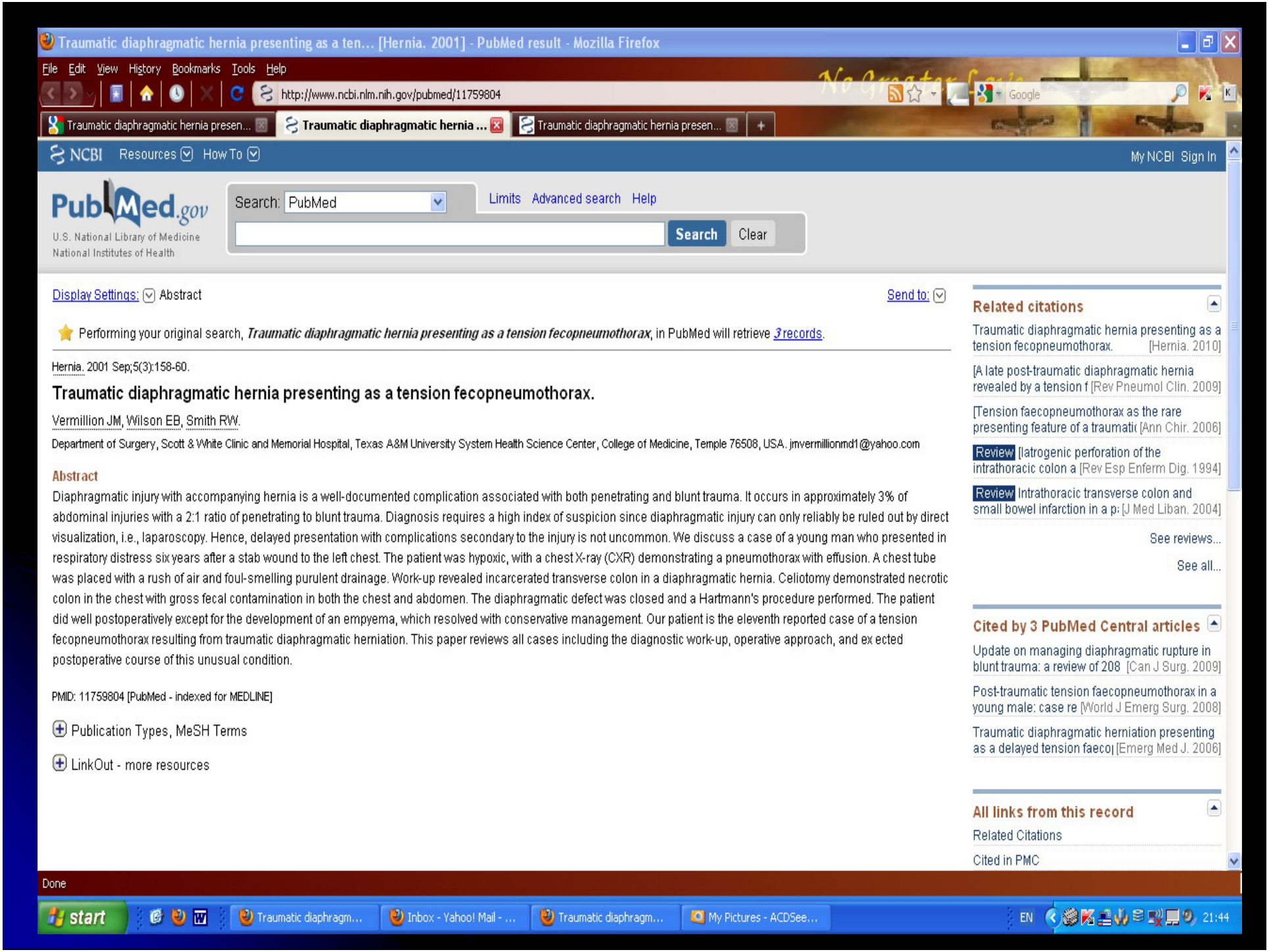
Outcome and Prognosis

- **Reported mortality ranges** from 5.5-51%.
- People with isolated diaphragmatic injuries tend to recover **without long-term disability**

Future and Controversies

- **Minimally invasive techniques** for diaphragmatic repair are becoming more common than before

- Both acute and chronic diaphragmatic hernias is possible with laparoscopic, thoracoscopic, or combined approaches


Traumatic diaphragmatic hernia presenting as a ten... [Hernia. 2001] - PubMed result - Mozilla Firefox
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U.S. National Library of Medicine
National Institutes of Health
Search: PubMed
Limits Advanced search Help
Search Clear
Display Settings: Abstract
Send to:
Performing your original search, Traumatic diaphragmatic hernia presenting as a tension fecopneumothorax, in PubMed will retrieve 3 records.
Hernia. 2001 Sep;5(3):158-60.
Traumatic diaphragmatic hernia presenting as a tension fecopneumothorax.
Vermillion JM, Wilson EB, Smith RW.
Department of Surgery, Scott & White Clinic and Memorial Hospital, Texas A&M University System Health Science Center, College of Medicine, Temple 76508, USA. jmvermillionmd1@yahoo.com
Abstract
Diaphragmatic injury with accompanying hernia is a well-documented complication associated with both penetrating and blunt trauma. It occurs in approximately 3% of abdominal injuries with a 2:1 ratio of penetrating to blunt trauma. Diagnosis requires a high index of suspicion since diaphragmatic injury can only reliably be ruled out by direct visualization, i.e., laparoscopy. Hence, delayed presentation with complications secondary to the injury is not uncommon. We discuss a case of a young man who presented in respiratory distress six years after a stab wound to the left chest. The patient was hypoxic, with a chest X-ray (CXR) demonstrating a pneumothorax with effusion. A chest tube was placed with a rush of air and foul-smelling purulent drainage. Work-up revealed incarcerated transverse colon in a diaphragmatic hernia. Celiotomy demonstrated necrotic colon in the chest with gross fecal contamination in both the chest and abdomen. The diaphragmatic defect was closed and a Hartmann's procedure performed. The patient did well postoperatively except for the development of an empyema, which resolved with conservative management. Our patient is the eleventh reported case of a tension fecopneumothorax resulting from traumatic diaphragmatic herniation. This paper reviews all cases including the diagnostic work-up, operative approach, and ex ected postoperative course of this unusual condition.
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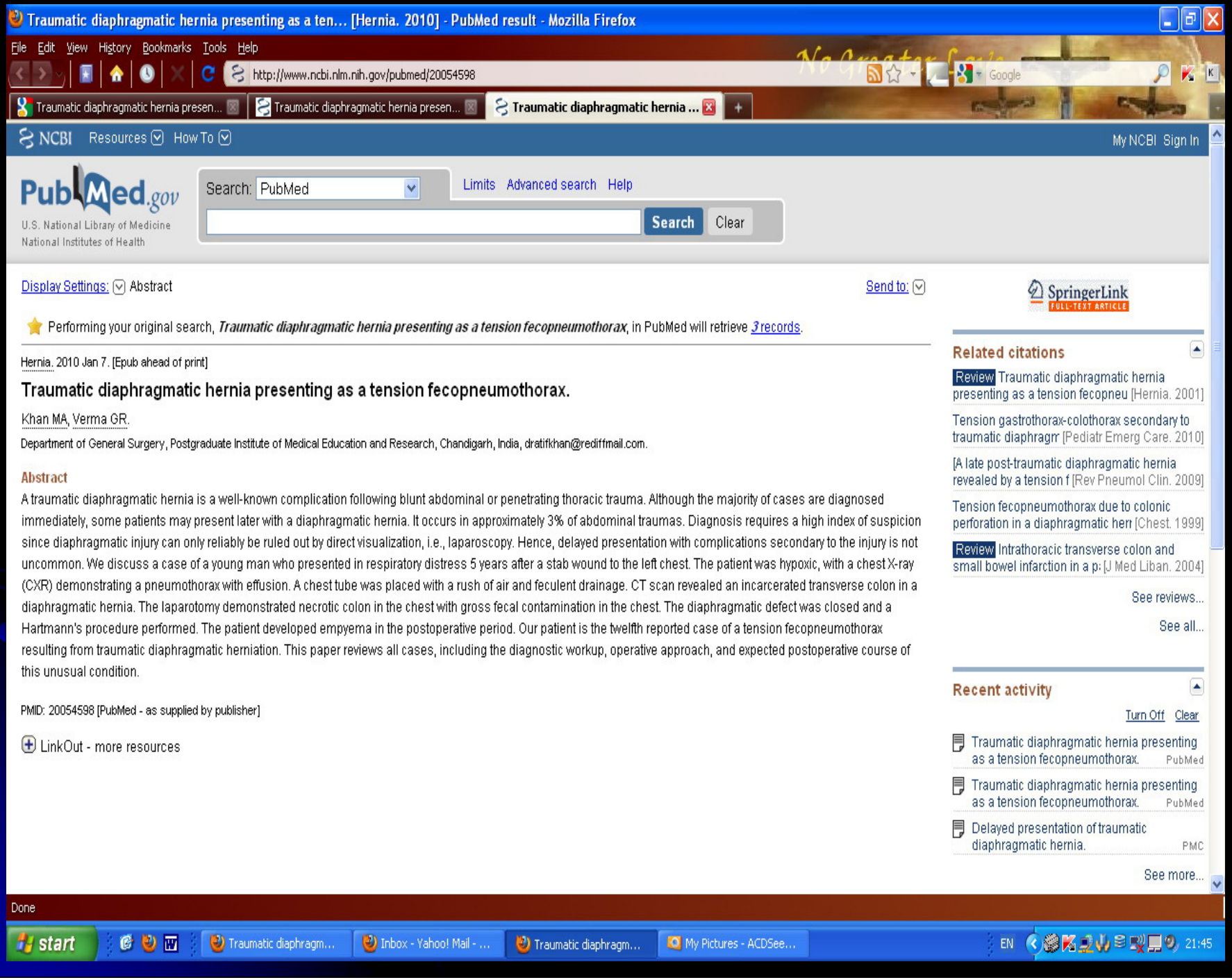
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Traumatic diaphragmatic hernia presenting as a tension fecopneumothorax.
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Abstract
A traumatic diaphragmatic hernia is a well-known complication following blunt abdominal or penetrating thoracic trauma. Although the majority of cases are diagnosed immediately, some patients may present later with a diaphragmatic hernia. It occurs in approximately 3% of abdominal traumas. Diagnosis requires a high index of suspicion since diaphragmatic injury can only reliably be ruled out by direct visualization, i.e., laparoscopy. Hence, delayed presentation with complications secondary to the injury is not uncommon. We discuss a case of a young man who presented in respiratory distress 5 years after a stab wound to the left chest. The patient was hypoxic, with a chest X-ray (CXR) demonstrating a pneumothorax with effusion. A chest tube was placed with a rush of air and feculent drainage. CT scan revealed an incarcerated transverse colon in a diaphragmatic hernia. The laparotomy demonstrated necrotic colon in the chest with gross fecal contamination in the chest. The diaphragmatic defect was closed and a Hartmann's procedure performed. The patient developed empyema in the postoperative period. Our patient is the twelfth reported case of a tension fecopneumothorax resulting from traumatic diaphragmatic herniation. This paper reviews all cases, including the diagnostic workup, operative approach, and expected postoperative course of this unusual condition.
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