Complex gastro-oesophageal reflux disease

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Peptic strictures and dilatation Reflux-induced strictures are relatively rare in the era of PPIs as most patients will be treated empirically before long-term complications occur. These strictures generally respond well to dilatation and long-term treatment with a PPI. Antireflux surgery is an alternative to long-term PPI treatment, just as in uncomplicated GORD. Most patients do not require anything other than a standard operation. - Hiatus hernia and paraoesophageal (‘rolling’) hernia Hiatus hernia is a condition in which the abdominal contents migrate through the hiatal opening of the diaphragm into the mediastinum. There are four types of hiatus hernia (Figure 66.18): (i) the sliding hernia (type I), accounting for most hiatus hernias (85–95%), where the OGJ is herniated - upwards; (ii) the true paraoesophageal/rolling hernia (type II), where there is asymmetrical herniation of the stomach next to the oesophagus and the OGJ remains in its normal intra- abdominal position (this is relatively uncommon); (iii) the more common mixed sliding and paraoesophageal hernia (type III); and (iv) when abdominal viscera other than the stomach migrate into the hernia sac, it is classified as type IV . Hiatus hernia is closely related to advanced age and obesity . - A sliding hiatus hernia predisposes to GORD and is usually diagnosed in the presence of reflux symptoms. For asymptomatic patients, it can be an incidental finding on plain chest radiographs or CT as an intrathoracic gas bubble or fluid level (Figure 66.19). A paraoesophageal hernia, especially when large, presents more with obstructive symptoms. The term ‘giant paraoesophageal hernia’ is present when more than half of the stomach has herniated into the thoracic cavity (Figure 66.20). This may present as a surgical emergency if gastric volvulus occurs. It is more common for the stomach to rotate along its longitudinal axis, termed organoaxial volvulus. When the stomach rotates around the transverse axis, it is called mesentericoaxial volvulus. Gastric volvulus can produce symptoms such as dysphagia - and chest pain. In severe cases, it can cause obstruction, stran - gulation, ischaemia, perforation and compression on the lungs, leading to impaired lung function. Emergency presentation and operation with any of these complications carries a high morbidity rate on account of a combination of late diagnosis, advanced patient age, comorbidities and the complexity of surgery involved. Therefore, all symptomatic paraoesophageal hiatus hernias should be repaired. The decision to repair an asymptomatic paraoesophageal hernia needs to balance risk with the patient’s age and comorbidities, as the annual risk of developing acute symptoms requiring emergency surgery is probably less than 2%. Patients who present acutely should first be resuscitated, followed by nasogastric tube decompression. Immediate sur gery is needed if there is suspicion of ischaemia, perforation or unresolved obstruction. The sur gical principle is similar to that of sliding hiatus hernia repair but more technically any herniated demanding. The steps include reduction of organ, extensive mediastinal dissection to restore the intra- abdominal length of the oesophagus, excision of the hernia sac to prevent a recurrence, repair of the crura in a tension- free manner and some

form of fixation of the stomach in the abdomen. Summary box 66.3 - Hiatus hernia /uni25CF /uni25CF /uni25CF

(a) (c) Figure 66.18 Types of hiatus hernias. (a) Type I, sliding hiatus hernia. paraoesophageal hernia. (d) Type IV, giant hiatus hernia with herniation of another abdominal organ, e.g. colon. (b) (d) (b) Type II, true rolling/paraoesophageal hiatus hernia. (c) Type III, mixed Type I sliding hernia predisposes to GORD Types II/III/IV paraoesophageal hernia present mainly with obstructive symptoms Volvulus and strangulation require emergency surgical treatment

Figure 66.19 Chest radiograph showing a gastric bubble in the lower mediastinum behind the heart corresponding to a hiatus hernia.

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