A 79-year-old man was admitted with a 3 day history of profuse vomiting. Plain chest x-ray on admission showed an elevated right hemidiaphragm. The abdominal film was within normal limits. A nasogastric tube was inserted and the patient was rehydrated. Subsequent CT of chest and abdomen demonstrated an anterior diaphragmatic hernia with the antrum, body and pylorus of stomach, along with the transverse colon in the chest (figures 1–3). The patient underwent a successful laparoscopic repair, with reduction of the contents and closure of the defect by means of a composite mesh repair. Non-traumatic diaphragmatic herniae causing gastric outlet obstruction are uncommon in adulthood. They usually present as a result of a previously undetected congenital hernia. In contrast to the posterolateral Bochdalek hernia, which is most frequently found on the left side of the diaphragm, a Morgagni hernia arises anteriorly through the sternocostal hiatus of the diaphragm most frequently on the right side. The incidence of Morgagni hernia among all diaphragmatic defects is less than 5%. The majority of Morgagni herniae are asymptomatic and are detected incidentally in adulthood. They may present as emergency with shortness of breath, gastric outlet obstruction, or acute strangulation and peritonitis.1 CT remains the preferred imaging modality as plain films are often non-specific. Surgical repair is usually required in these acute presentations, but should be considered for asymptomatic cases to avoid the future risk of strangulation.2
Competing interests None.
Patient consent Obtained.

REFERENCES

Figure 3 CT scan transverse slice showing stomach (S) and transverse colon (TC) in the right side of the chest. A nasogastric tube (NG) is noted in the oesophagus adjacent to the aorta (Ao) in the posterior mediastinum with the left lung (LL) in its normal anatomical position.