A rare sequela of chronic pseudo-obstruction

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DESCRIPTION

We report the case of a 67-year-old man with chronic pseudo-obstruction who presented to hospital with bilateral lower leg cellulitis. His medical history included depression and anxiety. Surgical history included a perforated sigmoid volvulus that required an emergency laparotomy and Hartmann's procedure 16 years previously. The end colostomy was subsequently reversed 1 year later. Five years following that, the patient experienced symptoms of pseudo-obstruction requiring hospitalisation and decompression with flatus tube insertion.

On examination the patient was comfortable with all observations within normal range. His abdomen was soft, non-tender and distended. No abnormality was detected on digital rectal examination. A routine chest X-ray showed a markedly abnormal left hemithorax filled with air, and mediastinal shift to the right (figure 1). CT of the chest demonstrated markedly dilated colon lying in the left hemithorax causing mediastinal shift to the right and left lung collapse (figure 2). A water soluble enema demonstrated evidence of pseudo-obstruction with transverse colon lying in the left hemithorax. Flexible sigmoidoscopy was carried out with good decompression of the large bowel. This case demonstrates a most unusual complication of chronic pseudo-obstruction, with a large paraoesophageal hernia developing due to lack of capacity of the peritoneal cavity to accommodate the chronically dilated colon.

Figure 1 Markedly abnormal chest X-ray with an air-filled left hemithorax and mediastinal shift to the right-hand side.

Figure 2 Axial image from the subsequent CT scan at the level of T5 in the mediastinal window demonstrating bowel in the left hemithorax, left lung collapse and mediastinal shift.

The most serious potential complication is bowel strangulation and perforation.¹ Surgical management takes the form of laparoscopic or open paraoesophageal hernia repair, mesh repair of the defect and colopecty.^{2 3} This case demonstrates a rare finding on chest X-ray that may be easily misdiagnosed.

Learning points

- ▶ A chest X-ray of this appearance must prompt consideration of tension pneumothorax, large lung bulla and paraoesophageal hernia as potential causes.
- ▶ Paraoesophageal hernia may rarely present as a complication of chronic pseudo-obstruction.
- ▶ Surgical correction may take the form of mesh repair and colopecty.

Competing interests None.

Patient consent Obtained.

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