Information Snapshot – **Dr Jonathan Foo**

Clinical Update on Hiatial Hernia

Symptoms

Common: reflux, epigastric pain, regurgitation and upper GI bleeding

Uncommon due to mass effect/volvulus shortness of breath, aspiration, severe pain

Diagnosis

On endoscopy or CT

Type (Bariatric is a new group)

Hernia type will dictate symptoms

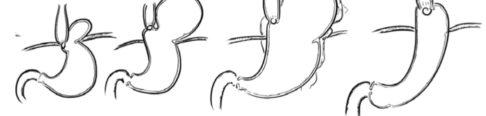
95%

Type 1

Sliding Hernia: if symptomatic these present as GORD

5%

Type II | Type III | Type IV | Bariatric



Rolling/Mixed and Bariatric (migrated sleeve gastrectomy and post gastric band): symptoms can be GORD/volvulus or mass effect related

Specialist Review if symptomatic Type I or Uncommon Types

Manometry +/- 24 hour pH to exclude oesophageal dysmotility disorders which may alter approach

Collaborative decision making

Examples where careful discussion may be required:

- GORD Refractory to PPI
- Hiatal hernia post sleeve gastrectomy
- Asymptomatic with Barrett's Oeosphagus
- The asymptomatic giant hiatal hernia

Laparoscopic Hiatal/Paraoesophageal Repair

2-3 day stay in Hollywood Private Hospital depending on repair type

Hiatal Hernia: An Update

Up to 20% of the general population experience gastro-oesophageal reflux symptoms and many of these people have a a hiatal hernia where a portion of the stomach has been pushed up into the thoracic cavity. The most common type of hiatal hernia is a "sliding hernia" and these are often managed with proton pump inhibitors and lifestyle therapy such as weight loss. These only require referral for consideration for fundoplication surgery if they remain symptomatic with GORD symptoms.

Fundoplication surgery involves wrapping the fundus around the abdominal oesophagus to mechanically recreate the lower oesophageal sphincter.

There are uncommon types where the stomach rolls into the mediastinum, where there is a large volume of stomach with other organs herniating into the thoracic cavity.

A new subset of patients with reflux are people who have had bariatric surgery and consequential symptoms. For example, patients may have migration of their sleeve gastrectomy into their thoracic cavity or an adjustable gastric band may have caused a proximal gastric pouch to have reflux. Establishing true reflux versus oesophageal motility disorders in these patients can be difficult and these often require a review by an upper gastrointestinal specialist to assess if anti-reflux surgery may help.

About Mr Jonathan Foo

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Mr Jonathan Foo is a specialist Upper Gastrointestinal, Bariatric and General Surgeon based at the Upper Gastrointestinal Unit at Sir Charles Gairdner Hospital and at Hollywood Private Hospital with Perth Upper GI. He provides dedicated care for pathologies such as reflux, hiatal hernia, gallbladder disease and abdominal wall hernias. He has a particular interest in gastro-oesopahgeal cancer and bariatric surgery. Above all, Jonathan believes in surgical excellence and quality of life following your surgery.
For more information on Mr Jonathan Foo please click here

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