Commentary: Watch and wait for disaster? Is it safe to watch and wait paraconduit hernias following esophagectomy?

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The repair of paraconduit hernia is always a topic of lively debate among general thoracic surgeons. In one corner, you have surgeons who believe observing asymptomatic paraconduit hernias puts patients at risk for incarceration, strangulation, or perforation if left untreated. In the other corner, you have surgeons who believe patients with asymptomatic paraconduit hernias can be safely observed, since most are incidentally discovered and very few ever become symptomatic. In this current issue of the Journal, Barron and colleagues1 perform a review of the incidence and management of paraconduit hernias from more than 1200 esophagectomies performed at the Cleveland Clinic between 2006 and 2021. They found the incidence of paraconduit hernia was 2.5% at 3 years and 5.7% at 10 years. Of the 37 patients found to have a paraconduit hernia, only 7 patients were found to be symptomatic and 4 patients underwent repair. All 4 patients underwent successful repair via laparotomy, with 2 of 4 patients undergoing mesh repair of the hiatus. This paper again highlights the low incidence of paraconduit hernias after esophagectomy and even lower incidence of symptomatic paraconduit hernias.

These data are in line with previously published reports of paraconduit hernia rates of 0.7% to 15% and benefits from excellent long-term follow-up.2,3 An interesting question raised in this paper is when a paraconduit hernia should be considered symptomatic. The authors suggested symptoms included abdominal pain, constipation, nausea, dysphasia, and chest pain. Unfortunately, many of these symptoms are experienced by patients who have undergone an esophagectomy without a paraconduit hernia. Distinguishing between asymptomatic and symptomatic patients is a diagnostic dilemma in which clinical expertise and intuition may trump any single radiographic finding. However, development of new symptoms after esophagectomy with a new diagnosis of paraconduit hernia without other obvious anatomic abnormalities warrants repair.

An argument for early repair includes 2 papers cited by the authors: Matthews and colleagues4 described more than one half of patients with hernia requiring emergent repair and Brenkman and colleagues5 reported that one-third of patients presented emergently. The consequences of emergent repair in those studies were in hospital mortality rates of roughly 20%. These data highlight the challenge in waiting for patients to become symptomatic and the potential mortality associated with emergent repair. The authors in their own series had one symptomatic patient who was not fit enough for repair and, given the advanced age of many patients who undergo esophagectomy, there may be a window of opportunity for repair of both symptomatic and asymptomatic patients. This study will likely not settle the debate on whether to perform a watch-and-wait approach for asymptomatic paraconduit hernias; however, it adds to the literature that watchful waiting is an acceptable approach. In addition, with the increase of

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minimally invasive esophagectomy, there is concern that paraconduit hernia will be an increasing challenge faced by thoracic surgeons. Ultimately, using sound clinical judgment along with the use of computed tomography imaging or barium swallows and proper long-term follow-up will help guide decision-making without a one-size-fits-all approach.

Conflict of Interest Statement
The author reported no conflicts of interest.

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