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

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

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**Central Message:** The authors conclude paraconduit hernias may occur several years following esophagectomy and a watch and wait approach for asymptomatic paraconduit repair may be a reasonable approach.

**Central Picture Legend:** Kiran Lagisetty, MD

The repair of paraconduit hernia is always a topic of lively debate amongst General Thoracic surgeons. In one corner you have surgeons who believe observing asymptomatic paraconduit hernias put 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 JTCVS, Barron, et.al., perform a review of the incidence and management of paraconduit hernias from over 1200 esophagectomies performed at the Cleveland Clinic between 2006 and 2021.1 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 out 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.

This data is in line with previously published reports of paraconduit hernia rates of 0.7 – 15%
and benefits from excellent long term followup. 2-3 An interesting topic raised in this paper is when is a paraconduit hernia 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 where 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 two papers, cited by the authors, Matthews et.al described more than half of hernia patients requiring emergent repair and Brenkman et.al. where one-third of patients presented emergently. 4-5 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 esophagectomy patients, 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 adds to the literature that watchful waiting is an acceptable approach. In addition, with the increase of minimally invasive esophagectomy, there is concern that paraconduit hernia will be an increasing challenge faced by thoracic surgeons. Ultimately, using sound clinical judgement along with utilization of CT imaging or barium
swallows and proper long term follow up will help guide decision making without a one-size fits all approach.

References


