SYNCOPE CAUSED BY HUGE HIATAL HERNIA

EDLIRA KOKONOZI1, REZARTA KAZAZI2, JONIDA PECI3
1Anaesthesiologist-Intesivist-Hospital of Librazhd District-Elbasan Albania
2Pneumologist-Hospital of Librazhd District-Elbasan Albania
3Jonida Peci Anaesthesiologist-Intesivist-American Hospital-Tirana Albania
Correspondence author e-mail: edlira.kokonozzi@yahoo.com

Abstract
A 74 year old female had sudden loss of consciousness while cleaning the house. A few minutes before the episode she has eaten meal and has drunk coffee. She was presented at emergency room with altered mental status, fecal & urine incontinence, tachypnea, pallor, vomiting, profuse sweating. A careful history is taken by witness and a detailed physical examination didn’t revealed any cause of syncope. A chest X-Ray was performed and after this a chest Fluoroscopy in advance which was essential to make diagnosis. There was a large retro cardiac opacity with air and liquid level compatible with a giant hiatus hernia. This can cause syncope by impeding blood flow from left atrium to the left ventricle. The diagnosis confirmed with thoracic-abdominal CT-scan. There was a huge hiatal hernia with air-fluid level behind the heart in close relation to the left atrium. After recovery the patient was treated with antibiotics for aspiration pneumonia and she was referred to Universal Hospital Mother Theresa of Tirana for surgery treatment.

Key words: syncope, hiatal hernia, retro cardiac, CT-scan

Introduction
This case was one of the situational syncope that is diagnosed if syncope occurs during or immediately after specific triggers: gastrointestinal stimulation (swallow, defecation and visceral pain), micturition (post micturition), post exercise, post prandial, cough, sneeze, and others (laughing, brass instrument playing, and weightlifting) This clinical case had been a diagnostic of challenge. Patient history and physical examination did not revealed any cause of syncope. The chest x-Ray and chest Fluoroscopy uncovered the cause of syncope. The diagnosis confirmed by thoracic-abdominal computed tomography CT-scan. The patient had no any information about her huge hiatal hernia. Patient didn’t take any drugs for any diseases.

Presentation of case
We presented a rare case of syncope that was presented in our emergency department because she had sudden loss of consciousness after eating meal and after a physical effort. This condition was proceeded by nonsense talking, unpleasant feeling, and warmth feeling. The whole history was taken by wife of her son as a witness. She presented at the emergency department in post syncope phase with altered mental status, fecal & urine incontinence, tachypnea, pallor, vomiting, profuse sweating. After recovery the patient felt very tired and didn’t remembered anything. A detailed physical examination was done. We founded normal sinus rhythm pulse rate 76/min with arterial pressure 130/90 mmHg. Lung auscultation: crackling sounds and slight down saturation peripheral oxygenation Sp02 92% that arise a suspicion of aspiration pneumonia that was confirmed with chest X-Ray. Neurologic examination: without deficits of limbs, pupils with normal size. Patient had fatigue and was orientated in time and place. Patient had an episode of fever 38.5 grade Celsius after 3 hours and cough due to aspiration pneumonia. No injury was founded. Patient hospitalized in the intensive care unit for further examinations. A total blood account and complete metabolic panel was normal. An ECG with 12 lead was performed that shows sinus rhythm. Abdominal echography was normal. Two dimensional
Echocardiography demonstrated a hiperechogen mass compressing the left atrium from the posterior. Cardiac parameters was within normal limits. The chest X-Ray is the appropriate diagnostic test in this unusual type of syncope.

There is a dense opacity behind cardiac silhouette and bibasal density that increased the suspicions so the patient was examined in advance with Chest-Fluoroscopy. There was a large retro cardiac opacity with air and liquid level compatible with a giant hiatus hernia (impossible to save the image of fluoroscopy). The diagnosis confirmed with thoracic-abdominal CT-scan. There was a retro cardiac mass with air-fluid level next to the left atrium that was compatible with a hiatal hernia.

The patient monitored in the intensive care unit for vital signs and observed up to full recovery. She had a spontaneous neurologic recovery. The further treatment was directed for the aspiration pneumonia.

**Discussion**

The “initial evaluation” of a patient presenting with syncope consists of taking a careful history, and a physical examination, including orthostatic blood pressure measurements and standard electrocardiogram (ECG). Differentiating true syncope from “non-syncopal” conditions associated with real or apparent transient loss of consciousness is generally the first diagnostic challenge and influences...
the subsequent diagnostic strategy. The absence of signs of suspected heart disease excludes a cardiac cause of syncope. Neurologic disease may cause transient loss of consciousness (for example, certain seizures), but is almost never the cause of syncope. Thus, neurologic testing may be needed to distinguish seizures from syncope in some patients, but these should not be considered as essential elements in the evaluation of the basis of true syncope. We found the same rare cases at the literature with “non-classical” presentations. These forms are diagnosed by minor clinical criteria, exclusion of other causes for syncope (absence of structural heart disease) etc.

Conclusions
We present a rare case of the situational syncope triggering from gastrointestinal stimulation and physical efforts. The large hiatal hernia impending the blood flow from the left atrium to the left ventricle decreasing cardiac output as the sole mechanism of syncope episode.

References
3. Reference 1 and 2 are important consensus documents describing a standardised strategy for the evaluation and the treatment of patients with syncope