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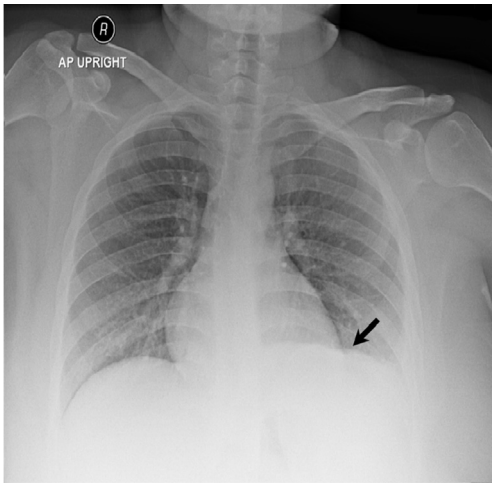

Figure 1. Chest radiograph showing elevation of the left diaphragmatic shadow (arrow).

Figure 2. Computed tomography of the abdomen (axial view) showing a 4-cm diaphragmatic defect at postero-lateral aspect of left hemidiaphragm with a part of the colon and its mesenteric fat trapped inside (arrow).

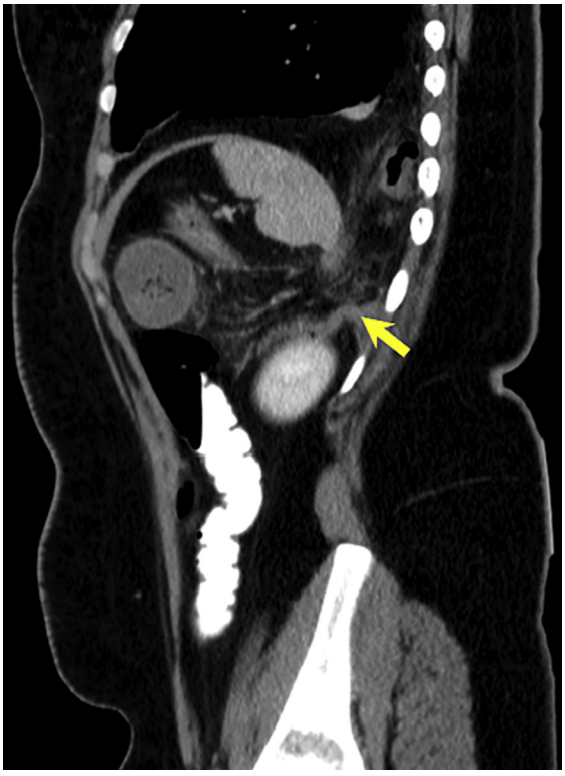

Figure 3. Computed tomography of the abdomen (sagittal view) showing a defect at posterior aspect of left hemidiaphragm with herniation of the mesocolon (arrow).

[Ann Emerg Med. 2017;69:e25-e26.]

A 21-year-old woman who had intermittent history of acid-related dyspeptic pain presented to the emergency department with 5 days of worsening colicky epigastric pain and occasional vomiting. The patient had been treated with oral antacid medications, without improvement. She had not experienced any traumatic event. Her physical examination showed normal vital signs but was pertinent for mild tenderness over the epigastric and left upper abdomen, without abnormal peritoneal signs. Chest radiograph revealed an elevation of the left hemidiaphragm (Figure 1). Computed tomography (CT) of the abdomen was conducted to identify the subdiaphragmatic pathology.

For the diagnosis and teaching points, see page e26.
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(continued from p. e25)

DIAGNOSIS:

Pseudoelevation of left hemidiaphragm caused by colonic incarceration into a congenital diaphragmatic defect (Bochdalek hernia). The CT scan demonstrated a diaphragmatic defect at the posterolateral aspect of the left hemidiaphragm, consistent with a congenital Bochdalek hernia, with herniation of the splenic flexure colon and its mesenteric fat (Figures 2 and 3). The patient was admitted to the hospital and underwent an urgent exploratory laparotomy with colonic reduction and closure of the diaphragmatic defect. The postoperative course was uneventful.

The presentation of congenital Bochdalek hernia during adulthood is not common and may frequently be diagnosed as dyspepsia.[1] Although most Bochdalek hernias are usually asymptomatic, they can be detected in up to 6% of the adult population.[2,3] Clinicians should suspect presence of the disease when an abnormal diaphragmatic silhouette or air-filled structure is observed over the lung on radiograph in patients with abdominal pain. Potential life-threatening complications (eg, bowel strangulation, perforation) can occur if surgical treatment is delayed.[4,5]

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