Latent Traumatic Diaphragmatic Hernia
A Surgical Challenge

To the Editor:

The article published in CHEST by Seelig and associates (January 1999) on a very rare complication of occult diaphragmatic hernia has an important theoretical and practical value.

Like the authors, we found that the diagnosis of blunt traumatic rupture of the diaphragm may represent a challenge. In the majority of 13 patients managed at our clinic between 1989 and 2000, the fact of blunt thoracic trauma and/or abdominal trauma had been forgotten and the injury to the diaphragm was not suspected before admission to the clinic. In three other cases, rupture of the left diaphragm was missed during the prior laparotomy, a recurrent left-sided diaphragmatic hernia was interpreted as a posttraumatic phrenic nerve palsy (at another institution), and an erroneous diagnosis of a massive hiatal hernia was made.

However, in all our patients the correct diagnosis was established preoperatively. In all instances, visceral herniation (ie, stomach, intestine, spleen, liver, and omentum) into the chest cavity was present, most commonly through the pericardiac area in the left and central tendon on the right side. A left posterolateral thoracotomy was the preferred approach, except in two cases in which a left thoracolaparotomy was required or on one occasion when a right thoracotomy was required for hernia repair with an interrupted suture buttressed with vicryl mesh.

The delay of the diagnosis in latent blunt diaphragmatic ruptures may be attributed to several factors, but a careful history of abnormalities, plain chest roentgenograms, CT scans, and barium studies of the alimentary tract are the most useful diagnostic tools. Extensive adhesions between the herniated viscera and the lung or pericardium are difficult to remove through laparotomy, so a transthoracic approach and suture-repair of the diaphragm is the best choice of procedure.

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References

Interpretation of Home Oximetry Tracings

To the Editor:

It was with great interest that we read the review dedicated to pulse oximetry that was published in August issue of CHEST. This review nicely highlights the benefits and limitations of such a recording tool in the screening of patients suspected of having sleep apnea syndrome. We agree with the authors that the utility of such a simple recording in our investigation strategy definitively needs to be addressed in this time when the referrals for sleep and breathing investigation are rapidly increasing. We were quite surprised to find out that the literature detailed in this review did not mention and discuss the results that we published in 1993 on the utility of home oximetry in a large sample of outpatients.

This study was the first to evaluate a new interpretation procedure for oximetry tracings that looked at the desaturation/resaturation pattern without considering any threshold for arterial oxygen saturation (SaO2) fall or minimal SaO2 amplitude to be