Parahilarli herniae have been noted in adults following surgical incision of the diaphragm, or hiatal hernia surgery. The etiology and embryology of the spontaneous defect is speculative. The defect occurs just lateral to the esophageal hiatus and one report considers it a failure of closure of the pleuro-peritoneal canal. However, the pleuro-peritoneal canal has also been implicated in the genesis of the more common pediatric congenital diaphragmatic hernia of Bochdalek, which is located posterolaterally. The symptomatology is similar to that of paraesophageal hernias, viz., features of acid-peptic reflux or mechanical gastric obstruction, volvulus, and strangulation of the intrathoracic stomach have also been reported.

Radiological diagnosis of the entity is difficult. Most plain films mimic a hiatal hernia, in our case an eventration was suspected. A few differentiating features in patients having parahilar herniae are: position of the intrathoracic viscus to the left of the midline, in contrast to the more central location in paraesophageal hernia; the presence of a band of tissue separating the contrast within the distal esophagus from the contrast in the herniated viscus; and the failure of the contrast to fully enter the herniated viscus if the defect in the diaphragm is small.

The size of the defect varies from 1 cm to 4 cm and the stomach is the usual herniated organ. Once the viscus is reduced and the hernial sac excised, repair can be accomplished by simply uniting the two edges of the defect by nonabsorbable sutures. In most cases, however, an antireflux procedure has been carried out as was done in this case, to ensure that reflux and secondary hiatal herniation do not result from the surgery.

This report supports the concept of the rare parahilar hernia, and close attention to its radiological features may allow a correct preoperative diagnosis to be made.

References
freed for a length of 6 cm. An 8-mm diameter PTFE interposition H graft was put between the inferior vena cava and inferior mesenteric vein using 5-0 continuous prolene stitches.

At 1-year follow up, the patient was free of further bleeding episode. Postoperative esophagoscopy showed that the esophageal veins had disappeared.

Dissection of the superior mesenteric vein at the root of the mesentery is a difficult and tedious procedure. The vein has to be circumferentially freed and this might require the ligation of numerous branches and collateral vessels that surround it. These collateral vessels are naturally occurring porto-systemic shunts and should be preserved as far as possible.

There are anecdotal reports in literature about using the inferior mesenteric vein for meso-caval shunt. Corini et al\textsuperscript{1} utilized the inferior mesenteric vein in 5 patients - 4 for inferior mesenteric-left renal vein shunt and one for inferior meso-caval shunt. They found the procedure to be technically straightforward, subtotally decompressing the portal vein and permanently controlling variceal bleeding. Deshmukh et al\textsuperscript{2} using the inferior mesenteric vein-to-left renal vein anastomosis in an end-to-side fashion found it to be specially useful in patients with difficult periportal or peri-pancreatic anatomic exposure. D'Cruz et al\textsuperscript{3} used this shunt for the emergency control of variceal bleeding. Montemurro et al\textsuperscript{4} used the inferior meso-caval shunt in a 67-year-old man with life-threatening bleeding from anorectal varices; immediate control of bleeding was achieved.

The inferior mesenteric vein is an important tributary of the portal venous system and joins the splenic vein proximal to its union with the superior mesenteric vein. The portal vein and its various tributaries are a valveless system and therefore pressure is equally distributed throughout the system. Therefore anastomosis of the inferior mesenteric vein to either the left renal vein or inferior vena cava is based on sound physiological principles for reducing portal hypertension. All authors have emphasized the technical ease, effectiveness and low procedure-related morbidity with this technique. One important advantage is that collateral channels and the naturally occurring porto-systemic shunts are minimally disturbed. Subtotal decompression of the portal system could lead to a lower rate of encephalopathy in comparison to other non-selective shunts.\textsuperscript{5} In patients with portal vein or splenic vein thrombosis, an inferior meso-caval shunt should be considered the procedure of choice.

References

Correspondence to: Dr R Khanna, A-15 Brij Enclave, Sundarpur, Varanasi 221 005. E-mail: dr.rehil_khanna@rediffmail.com
Received January 5, 2003. Accepted February 15, 2003