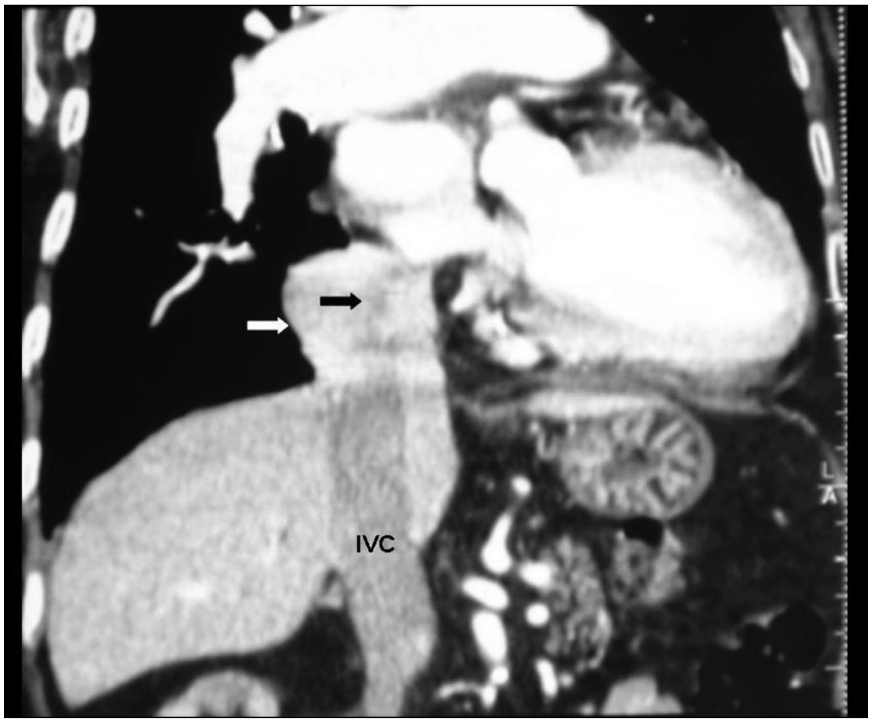

FIG. 2. Oblique coronal computed tomographic reconstructed view of the left liver lobe herniating through the diaphragmatic caval foramen (white arrow), with compression and tapering of the inferior vena cava (IVC) toward the right atrium (black arrow).

described in 1761. Morgagni hernia accounts for 3%–4% of all diaphragmatic defects and is the least common of the CDHs.[1] Classically, viscera herniate through the sternocostal trigone, which is a triangular space between muscle fibres from the xiphisternum and the costal margin fibres that insert on the central tendon of the diaphragm. Herniation is less common on the left (2%) because of the presence of the pericardial sac. Omentum, colon and, rarely, small bowel, stomach or liver may be found in the herniated sac.[1,2] Symptoms may include dyspnea, chest discomfort or pain, and chronic gastrointestinal symptoms. Less commonly, symptoms resulting from intestinal strangulation or obstruction and gastric volvulus formation have also been reported.[3] Diaphragmatic hernia may be suspected when a chest radiograph shows a paracardiac mass or a gas–fluid level at the mediastinum corresponding to the herniated bowel or stomach.[1,2] However, diaphragmatic hernias, in particular the Morgagni type, can be mistaken for lung consolidation or abscess, mediastinal tumour and pleuropericardial cyst.[2] CT imaging with reconstructed views is the investigation of choice for the diagnosis of CDH.[2] Barium enema, bronchoscopy and magnetic resonance imaging may be useful adjuncts when diagnostic uncertainty remains.[1] Surgical repair via the transabdominal approach is popular, although repair can also be carried out through thoracotomy, or laparoscopically with or without a mesh.[4,5] We decided against surgical exploration and repair, because our patient was asymptomatic and because of the significant risks associated with anesthesia and surgery given the patient's age. Diaphragmatic hernia should be part of the differential diagnosis when a thoracic mass is detected on a chest radiograph.

Competing interests: None declared.

References

1. Fukamizu R, Hayashi S. Images in clinical medicine. Diaphragmatic hernia. *N Engl J Med* 2004;351:e22.
2. Schubert H, Haage P. Images in clinical medicine. Morgagni's hernia. *N Engl J Med* 2004;351:e12.
3. Lanteri R, Santangelo M, Rapisarda C, et al. Bilateral Morgagni-Larrey hernia: a rare cause of intestinal occlusion. *Arch Surg* 2004;139:1299-300.
4. Murray JA, Weng J, Velmahos GC, et al. Abdominal approach to chronic diaphragmatic hernias: Is it safe? *Am Surg* 2004;70:897-900.
5. Tarim A, Nursal TZ, Yildirim S, et al. Laparoscopic repair of bilateral morgagni hernia. *Surg Laparosc Endosc Percutan Tech* 2004;14:96-7.

Correction

The following acknowledgement should have been included in a recent *Canadian Journal of Surgery* article by John Kaspar, Sam Kaspar, Cinzia Orme and Justin de V. de Beer (Intra-articular steroid hip injection for osteoarthritis: a survey of orthopedic surgeons in Ontario. *Can J Surg* 2005;48[6]:461-9).

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