

Most of the Morgagni hernia has a hernial sac. Hernial sac frequently contains the omentum, transverse colon and rarely stomach or liver<sup>(5)</sup>. The present case had hernial sac that contained omentum and transverse colon. Patients with Morgagni hernia are usually asymptomatic. Among symptomatic patients; the complaints included shortness of breath, thoracic pain, nausea, vomiting, abdominal distension, and abdominal pain. The present case presented with shortness of breath, cough and fever (chest infection). The use of computed thoracoabdominal tomography as a diagnostic tool for Morgagni hernia has increased the reliability of preoperative diagnosis. Bilateral, big Morgagni hernia of the present case was diagnosed with chest radiography and Ba-enema without the need for CT scan. The treatment of Morgagni hernia is surgical and is indicated always after diagnosis because of the risk of visceral complications such as obstruction or strangulation.

Both transabdominal and transthoracic approaches are recommended in surgical repair of Morgagni hernia. Transthoracic repair has been used by Kilic *et al*<sup>(9)</sup> with favorable results. They recommended transthoracic approach because it provides sufficient exposure, easy repair of the hernial defect and facilitates the release of pericardial adhesions. But, they also reported that transabdominal approach should be favored, particularly in cases with bilateral hernial sac as in our patient. Transabdominal approach via laparotomy is superior in recognition and management of malrotation and for dealing with visceral complications than transthoracic approach. The present case was treated with an elective laparotomy and there were no postoperative complications. In conclusion, Morgagni hernia is a rare surgical problem. Bilateral Morgagni hernia is extremely rare and patient usually asymptomatic and discovered incidentally. Preoperative diagnosis may be aided by chest radiography and Ba-enema as in our current case and in questionable cases by

CT scans. The current treatment of a Morgagni hernia is surgical repair (open or laproscopically) because of the risk of visceral herniation and strangulation. Transabdominal approach is the preferred technique for reduction and dealing with visceral complications. The laparoscopic approach has the advantage that tissue trauma is kept to a minimum compared with the traditional open approach. The laparoscopic techniques have included a direct suture technique where the diaphragm is sutured to the retrosternal tissues using a Keith needle or inclusion of the whole of the upper abdominal wall in the repair with extracorporeal knots<sup>(10)</sup>.

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