I read with interest the article entitled ‘Intrathoracic gastric perforation: a late complication of an unknown postpartum recurrent hiatal hernia’ by Lococo et al [1]. A 62-year old man was referred to our centre with a case of left-sided traumatic chylothorax for the possibility of a thoracic duct ligation. A left-sided chest tube was draining several hundreds of millilitres of whitish milky fluid daily. Repeated chest X-rays were highly suggestive of a left traumatic diaphragmatic hernia. Chest CTs with both oral and intravenous contrast were done, which showed a defect on the left copula of the diaphragm with the whole stomach herniating into the chest and escape of oral contrast in the left pleural cavity. Exploratory thoracotomy was immediately decided upon. There was a 2-cm rupture in the lesser curvature of the stomach with the whole stomach in the chest with a thick pleural peel. The stomach defect was repaired in 2 layers of vicryl 1 followed by stapling. The stomach and omentum were reduced into the abdomen. The defect in the diaphragm was repaired with 2 layers of Prolene 1. The pleural peel was decorticated. The pericardial effusion was drained by a small pericardial window. The patient had a very smooth postoperative course.

To the best of our knowledge, very little is mentioned about traumatic ruptures of the herniated stomach in the chest.  

Conflict of Interest: None declared

References