Introduction

The diaphragm is a dome-shaped, musculoaponeurotic structure separating the thoracic and peritoneal cavities. This constantly active striated muscle increases the volume of the thoracic cavity with contraction and reduces thoracic volume on relaxation**. Christine & Bryan (2007).**

Diaphragmatic hernia is the main surgical condition of the diaphragm. This condition can be classified into congenital (Bochdalack, Morgagni and eventration of diaphragm), traumatic and hiatus hernia (Sliding, paraesophegeal). **Stolar et al., (1998).**

The development of the human diaphragm occurs between the 4th and 12th week of gestation. Traditional views of diaphragm development suggest that the diaphragm arises from four different structures**. Rottier et al., (2005).**

Hiatus hernia occurs when a portion of the stomach prolapsed through the diaphragmatic esophageal hiatus, although the existence of hiatal hernia has been described in earlier medical literature, it has come under close scrutiny only in the last century or so because of its association with gastroesophageal reflux disease and its complications. By far, the majority of hiatal hernias is asymptomatic and is discovered accidentally. On rare occasion a life threatening complications, such as gastric volvulus or strangulation, may present acutely**. Qureshi (2002).**

The incidence of esophageal hiatal hernia in the general population has been estimated variously at 2 to 6 percent. In addition, hiatal hernia may be noted in an estimated one of every five patients undergoing radiological examination of the esophagus**. Bancewicz (2000).**

Hiatus hernia is classified as type I, II, III, IV depending on the specific abnormality present. The term paraesophageal hernia is sometimes used to describe any type II, III, or IV hiatal hernia**. Fauza (2005).**

Hiatus hernia is rarely symptomatic (outside of GERD), although when large, may present with recurrent severe chest or epigastric pain and vomiting due to intermittent volvulus, or with GI bleeding due to linear hiatal ulcers ('Cameron's ulcers'). **Vivan and John (2007).**

Most patients complain of postprandial discomfort but a few complain of dysphagia. Substernal fullness or pressure is common and may be partially relieved by regurgitation. **Christine & Bryan (2007).**

The diagnosis hiatus hernia is usually first suspected because of an abnormal chest radiograph. The most frequent finding is a retrocardiac air bubble with or without an air fluid level, in a giant paraesophageal hernia; the hernia sac and its contents occasionally protrude into the right thoracic cavity. The differential diagnosis includes mediastinal cyst or abscess and dilated obstructed esophagus, as in end-stage achalasia. **Shields (2005).**

Three major types of surgical procedures correct gastroesophageal reflux and repair the hernia in the process including: Nissen fundoplication, Belsy Mark IV fundoplication, Hill repair. They can be performed by open laparotomy or laparoscopic approaches, which currently are being employed more frequently**. Qureshi (2002).**

With the introduction of the laparoscopic approach in the 1990s, the number of laparoscopic paraesophageal hernia repair performed annually has increased dramatically. Laparoscopic approaches are attractive as they combine the benefit of a less invasive approach with the outcome of a more traditional open surgical procedure. In most institutions, laparoscopic approach has become the preferred approach of paraesophageal hernia repair including the giant paraesophageal hernia**. Charles et al., (2007).**