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## **Hiatal hernia and Cameron ulcer: an overlooked association in pediatric patients**

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Dear Editor,

A ten-year-old boy presented with a two-year history of iron deficiency anemia (IDA) and occasional vomiting. His medical history included cerebral palsy and chronic pulmonary disease under mechanical cough assistance and nocturnal non-invasive ventilation. He had already been treated with proton-pump inhibitors (omeprazole 20 mg per day) and iron supplements because of a previous diagnosis of gastroesophageal reflux disease (GERD). Esophagogastroduodenoscopy revealed a sliding hiatal hernia and an 8-mm ulcer with a clean base, involving the diaphragmatic hiatus at the lesser curvature level, which was consistent with a Cameron ulcer. During the examination, it was possible to see the proximal stomach moving up and down through the diaphragmatic hiatus, with active oozing bleeding from the ulcer. A laparoscopic herniorrhaphy and fundoplication were performed. After 6-month follow-up, vomiting and IDA had totally resolved. Unfortunately, the patient died one year

later because of acute respiratory insufficiency.

Cameron lesions and hiatal hernias are uncommonly reported in adults evaluated for gastrointestinal bleeding, and the prevalence ranges from 0.6 % to 5 % (1). However, there are only a few case reports in children. Besides a poorly understood pathogenesis, it can be attributed to mechanical trauma of the hiatal hernia caused by respiration-related diaphragmatic movements and acid injury (2-4). We hypothesize that in our patient, the pressure difference between the abdomen and thorax generated by ventilatory support not only aggravated GERD but also contributed to an exacerbation of the hernia's sliding movement and distress of the mucosa, ultimately leading to ulceration. Pseudobulbar palsy with impaired airway clearance and lung function were the main causes of his unfavorable outcome.

Although a rare occurrence and cause of acute or chronic gastrointestinal bleeding (5), a hiatal hernia in a child with IDA should raise the suspicion of Cameron lesions. First-line treatment is long-term acid suppression and iron supplements. Surgery is recommended for patients whose lesions are refractory to medical treatment.

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