**Name of Journal:** *World Journal of Clinical Pediatrics*

**Manuscript NO:** 62339

**Manuscript Type:** CASE REPORT

**Chilaiditi syndrome in pediatric patients - Symptomatic** **hepatodiaphragmatic interposition of colon: A case report and review of literature**

Caicedo L *et al*. Chilaiditi syndrome in pediatrics

Luis Caicedo, Paul Wasuwanich, Andrés Rivera, Maria S Lopez, Wikrom Karnsakul

**Luis Caicedo,** Division of Pediatric Gastroenterology, Hepatology, and Nutrition, Nicklaus Children’s Hospital, Miami, FL 33155, United States

**Paul Wasuwanich,** Department of Medicine, University of Florida College of Medicine, Gainesville, FL 32610, United States

**Andrés Rivera,** Department of Pediatrics, Icahn School of Medicine at Mount Sinai, New York, NY 10092, United States

**Maria S Lopez,** Department of Pediatrics, Nicklaus Children’s Hospital, Miami, FL 33155, United States

**Wikrom Karnsakul,** Division of Pediatric Gastroenterology, Hepatology, and Nutrition, Department of Pediatrics, Johns Hopkins University School of Medicine, Baltimore, MD 21287, United States

**Author contributions:** Caicedo L, Rivera A, and Lopez MS collected data and drafted initial manuscript; Wasuwanich P collected data, carried out the formal analysis, and revised the manuscript. Karnsakul W conceptualized and designed the study, supervised the study, and revised the manuscript; all authors have reviewed the manuscript and approved the final manuscript as submitted and agree to be accountable for all aspects of the work;Caicedo L and Wasuwanich P are contributed equally to this study.

**Corresponding author: Wikrom Karnsakul, MD, Associate Professor,** Division of Pediatric Gastroenterology, Hepatology, and Nutrition, Department of Pediatrics, Johns Hopkins University School of Medicine, CMSC-2 600 North Wolfe Street, Baltimore, MD 21287, United States. wkarnsa1@jhmi.edu

**Received:** January 5, 2021

**Revised:** February 4, 2021

**Accepted:** March 10, 2021

**Published online:**

**Abstract**

BACKGROUND

Chilaiditi syndrome is a rare disorder characterized by the hepatodiaphragmatic interposition of the intestine.

CASE SUMMARY

Here we report a case of a 12-year-old male who was admitted to the pediatric intensive care unit secondary to abdominal pain and severe respiratory distress. He was treated conservatively but the symptoms persisted requiring a surgical approach. While there have been several cases of Chilaiditi syndrome reported in adults, there is a scarcity of cases reported in the pediatric population. Our review of the literature found only 30 pediatric cases, including our reported case, with Chilaiditi syndrome, 19 (63%) of which were male. The median age of diagnosis of 4.5 years old with an interquartile range of 2.0-10.0 years. In our review, we found that the most common predisposing factors in children are aerophagia (12/30 cases) and constipation (13/30 cases). Ninety percent of the cases presented with complete intestinal interposition, in 100% of which the colon was involved. Three of the 30 cases were associated with volvulus.

CONCLUSION

In the pediatric population, conservative (21/30 cases) and surgical (8/30 cases) treatment approaches have produced satisfactory outcomes for all the patients, regardless of approach.

**Key Words:** Abdominal pain; Dyspnea; Constipation; Rare diseases; Respiratory insufficiency; Colon; Case report

Caicedo L, Wasuwanich P, Rivera A, Lopez MS, Karnsakul W. Chilaiditi syndrome in pediatrics patients - Symptomatic hepatodiaphragmatic interposition of colon: A case report and review of literature. *World J Clin Pediatr* 2021; In press

**Core Tip:** We describe a pediatric case of Chilaiditi syndrome with successful treatment is reported along with literature review of all pediatric case reports of Chilaiditi syndrome. In the pediatric patients, conservative approaches in treating Chilaiditi syndrome with treatment of predisposing factors have resulted in satisfactory outcomes.

**INTRODUCTION**

Chilaiditi syndrome, first described by Viennese radiologist Dr. Chilaiditi[1] in 1910, is noted to be an extremely rare disorder associated with various symptoms including nausea, vomiting, abdominal pain, constipation, and respiratory distress. The condition is recognized radiologically by the presence of the hepatodiaphragmatic interposition of the intestine, called Chilaiditi sign. Chilaiditi sign can be confused radiologically with other conditions such as pneumoperitoneum and subdiaphragmatic abscess. The cause of Chilaiditi syndrome is currently unknown, but may include intestinal, diaphragmatic, or hepatic factors. While most cases can be managed conservatively, a few cases require surgical intervention[2]. We report a pediatric case of Chilaiditi syndrome and a literature review of a pediatric case series of Chilaiditi syndrome.

**CASE PRESENTATION**

***Chief complaints***

A 12-year-old male was admitted to the pediatric intensive care unit due to severe respiratory distress.

***History of present illness***

With this present admission, the patient presented with respiratory distress and right upper quadrant abdominal pain. He was placed on oxygen supplementation *via* nasal cannula to maintain normal oxygen saturations.

***History of past illness***

Prior to this admission, he experienced persistent cough, dyspnea, nausea, and chest pain for over two months. He was prescribed antibiotics, nebulizations, and pain medication; however, there were no improvements in his respiratory symptoms. The patient has a history of asthma, gastroesophageal reflux disease, constipation, and a prior diagnosis of Chilaiditi syndrome. The diagnosis of Chilaiditi syndrome was made two years prior to this admission when the patient presented with a 1-wk history of right upper quadrant pain, nausea, and vomiting. There was no history of recent weight loss. An abdominal computerized tomography (CT) showed constipation and colonic interposition between the liver and the diaphragm with displacement of the liver (Figure 1). Constipation was initially managed with a routine bowel cleansing protocol and a daily stool softener; however, intermittent episodes of abdominal pain persisted.

***Personal and family history***

No relevant family history.

***Physical examination***

No relevant physical examination.

***Laboratory examinations***

Laboratory results from complete blood count, comprehensive metabolic panel, and C-reactive protein were within normal limits.

***Imaging examinations***

A chest X-ray revealed that the transverse colon was above the liver. On the first hospital admission day, a kidney, ureter, and bladder X-ray (KUB) showed significant amount of fecal material and air-filled colonic loops which were slightly dilated and reaching the right hemidiaphragm (Figure 1).

**FINAL DIAGNOSIS**

A final diagnosis of Chilaiditi syndrome was given.

**TREATMENT**

He subsequently received a bowel-cleaning regimen with GoLytely®. A follow-up KUB on the second hospital admission day showed the resolution of fecal retention or constipation. However, the patient continued to complain of tachypnea and right upper quadrant pain. Because of his persistent respiratory and abdominal symptoms, and due to the lack of significant improvement, surgery was consulted. The patient underwent laparoscopic colopexy and peritoneal abrasion of the diaphragm and liver. Significant intraoperative findings included a redundant transverse colon, no evidence of volvulus or adhesions in the upper abdomen, a relatively small right liver lobe (noncirrhotic), and a large gap between the liver and the anterior chest wall and diaphragm.

**OUTCOME AND FOLLOW-UP**

His respiratory distress and abdominal pain resolved completely post-operatively and the patient was discharged with a maintenance stool softener regimen, colonic stimulant, and adequate dietary fiber. At the one-month follow-up after surgery, the patient reported regular bowel movements and no recurrence of his respiratory distress. He reported some mild intermittent episodes of right upper quadrant abdominal pain but never required emergency care or any interventions since the surgery.

**DISCUSSION**

The essential hallmark of Chilaiditi sign in Chilaiditi syndrome is that the air-filled loops of intestine remain unchanged in position of the patients due to its immobilization in a relatively limited space between the liver and the anterior chest wall[3]. Chilaiditi sign may be described as an incidental finding on plain radiological studies in asymptomatic patients. It is thought to occur in 0.025% to 0.28% of the general population. It is markedly more prevalent in the elderly and in men. This increased prevalence in the elderly suggests that it is an acquired rather than a congenital condition. Torgersen reported the prevalence of Chilaiditi syndrome to be 0.2% in men older than 65 years and 0.02% in men 15-65 years, with a male to female ratio of 4:1[4]. Murphy *et al*[5] associated Chilaiditi syndrome with being overweight or obese. Five of his ten patients found to have Chilaiditi syndrome on abdominal CT were obese (850 patients in the study, 10 of whom had Chilaiditi syndrome)[5]. In obese patients, a significant amount of fat accumulates between liver and diaphragm, with secondary widening of potential space, which is subject to substantial swings in pressure during the respiratory cycle. Following the same concept, the increased proportion of intraabdominal fat among men compared with women might explain the increased prevalence of Chilaiditi syndrome in men[6]. While there have been severe cases of Chilaiditi syndrome reported in adults, there is a scarcity of cases reported in the pediatric population. Our review of the literature found only 30 pediatric cases with Chilaiditi syndrome, 19 (63%) of which were male (Table 1). The median age of diagnosis was 4.5 years old with an interquartile range of 2.0-10.0 years[7-28].

The etiology of Chilaiditi syndrome has been categorized into (1) Intestinal: megacolon, abnormal colonic motility or redundancy, constipation, and congenital malrotation; (2) Hepatic: Cirrhosis, segmental agenesis of the right lobe of the liver, and relaxation of the hepatic suspensory ligament; and (3) Diaphragmatic: phrenic nerve injury and diaphragmatic eventration[15,17]. Several risk and predisposing factors have been associated with this entity including, aerophagia, adhesions, obesity, constipation, mental retardation, pregnancy, muscular dystrophy, and significant weight loss[17,22]. Very rarely, episodes of volvulus have been associated to this syndrome, especially in the elderly population and could be complicated with cecal perforation[4,7,22,29,30]. Chilaiditi syndrome can further be divided in two types, depending on the degree of intestinal interposition and liver displacement: (1) In the complete form, the colon typically lies above the liver, there being contact between the liver and diaphragm, with the liver displaced inferiorly, anteriorly, and medially; And (2) in the incomplete (partial) form, the colon does not typically rise above the liver, but lays lateral or posterior to it[23]. In theory, patients after orthotic liver transplantation will have some degrees of intestinal interposition with the transplanted liver being displaced inferiorly, anteriorly, and medially.

In our review of the pediatric literature, we found the most common predisposing factors in children to be aerophagia (12/30 cases) and constipation (13/30 cases). Ninety percent of the cases presented with complete intestinal interposition, in 100% of which the colon was involved. Three of the 30 cases were associated with volvulus. In the case we described here, the predisposing factor was believed to be a combination of constipation, redundant colon, and intestinal dysmotility, associated with a relatively small right lobe of the liver, in turn, allowing a big space between the liver and the anterior chest wall and diaphragm.

The most common clinical presentation of Chilaiditi syndrome is constipation, abdominal pain, nausea, vomiting, abdominal distention, and respiratory distress. On physical examination, it is possible to encounter loss of hepatic dullness on percussion (Joubert sign)[7,8,23,25]. The diagnosis of hepatodiaphragmatic interposition can be demonstrated with radiologic tests such as a plain KUB, a right upper quadrant ultrasound or an abdominal CT scan. Identifying haustra or plicae circularis between the liver and the diaphragm can distinguish pneumoperitoenum from Chilaiditi syndrome.

The majority of the cases with Chilaiditi syndrome require a conservative therapy which includes bed rest in a supine position, daily maintenance bowel regimen with laxatives and normal fiber diet, frequent bowel cleansing, fluid supplementation, and nasogastric decompression[23,25]. In some specific cases emergency surgery may be required: associated volvulus, internal hernia, or acute intestinal obstruction[7,9,22,30,31]. Cases who have lack the aforementioned surgical conditions and continue to have intractable abdominal pain and respiratory distress may benefit from undergoing a colopexy[6,9,23]. Colopexy is a surgical procedure which involves repositioning of the colon to adhere to the abdominal wall. In our literature review, 21 of the 30 reported cases were managed with a conservative approach and 8 required a surgical intervention (3 had associated volvulus, 4 presented with persistent respiratory distress, and 2 with recurrent vomiting). And of those 8 cases that required surgery, 2 were transverse colectomies, 2 were colopexies, 1 was a colopexy with transverse colectomy, 1 was detorsion, and 2 involved correction of diaphragmatic eventration and elevation of the right hemidiaphragm (Table 1). Of the 30 cases with reported outcomes, the final outcome was satisfactory for all those cases regardless of the treatment approach[6,7,9,22,23].

The teaching point of this uncommon but intriguing syndrome is to have a high index of suspicion of this condition in patients who have predisposing factors. In addition, it is essential to exclude pathologic conditions such as pneumoperitoneum, subphrenic abscess, posterior hepatic lesions, and Morgagni hernia, which can mimic Chilaiditi sign on a radiologic film. A subphrenic abscess usually features a comparatively smaller air fluid level in the right upper quadrant often associated with pleural effusions and basilar atelectasis (this last two conditions not commonly seen with Chilaiditi sign), if the diagnosis is unclear, an abdominal CT scan is recommended for further evaluation[3,23]. In patient with cirrhosis (in the absence of ascites), the prevalence of Chilaiditi sign has been reported be between 5% and 20%, higher than the general population[31,32]. It is essential to recognize Chilaiditi syndrome particularly in medical procedures requiring percutaneous transhepatic approach such as percutaneous liver biopsy, percutaneous transhepatic cholangiography, or biliary drainage. Real-time ultrasound guide during these procedures can prevent the intestinal injury before the percutaneous access to the liver[33].

**CONCLUSION**

Chilaiditi syndrome is a rare condition especially among the pediatric population. It should be suspected when patients present with constipation, abdominal pain (particularly located in the right upper quadrant), nausea, vomiting, abdominal distention, and respiratory distress of unknown cause. In the cases previously reported, there were no data about recurrence or timeline from first symptomatology to diagnosis; given the lack of information, long-term follow-up in these cases is necessary. In the pediatric population, both conservative and surgical approaches in treating Chilaiditi syndrome, with treatment of the predisposing factors, have resulted in satisfactory outcomes.

**ACKNOWLEDGEMENTS**

We would like to thank Dr. Colombani P for performing the surgery on our patient reported in this article.

**REFERENCES**

1 **Chilaiditi D.** Zur Frage der Hepatoptose und Ptose im allgemeinen im Anschluss an drei Falle von temporarer, partieller Leberverlagerung. *Fortcshr Geb Rontgenstr Nuklearmed Erganzongsband* 1910; **16**:173-208

2 **Kumar A**, Mehta D. Chilaiditi Syndrome. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing, 2021 [PMID: 32119452]

3 **Lo BM**. Radiographic look-alikes: distinguishing between pneumoperitoneum and pseudopneumoperitoneum. *J Emerg Med* 2010; **38**: 36-39 [PMID: 18762401 DOI: 10.1016/j.jemermed.2008.01.011]

4 **Torgersen J**. Suprahepatic interposition of the colon and volvulus of the cecum. *Am J Roentgenol Radium Ther* 1951; **66**: 747-751 [PMID: 14878056]

5 **Murphy JM**, Maibaum A, Alexander G, Dixon AK. Chilaiditi's syndrome and obesity. *Clin Anat* 2000; **13**: 181-184 [PMID: 10797624 DOI: 10.1002/(SICI)1098-2353(2000)13:3<181::AID-CA4>3.0.CO;2-7]

6 **Platz TA**, Barker M, Carlo J, Lord J. Chilaiditi syndrome--an interesting complication in a bariatric surgery patient. *Surg Obes Relat Dis* 2006; **2**: 57-8; discussion 59-60 [PMID: 16925321 DOI: 10.1016/j.soard.2005.10.011]

7 **Barroso Jornet JM**, Balaguer A, Escribano J, Pagone F, Domenech J, del Castillo D. Chilaiditi syndrome associated with transverse colon volvulus: first report in a paediatric patient and review of the literature. *Eur J Pediatr Surg* 2003; **13**: 425-428 [PMID: 14743335 DOI: 10.1055/s-2003-44737]

8 **Dogu F**, Reisli I, Ikinciogullari A, Fitöz S, Babacan E. Unusual cause of respiratory distress: Chilaiditi syndrome. *Pediatr Int* 2004; **46**: 188-190 [PMID: 15056249 DOI: 10.1046/j.1442-200x.2004.01856.x]

9 **White JJ**, Chavez EP, Souza J. Internal hernia of the transverse colon-Chilaiditi syndrome in a child. *J Pediatr Surg* 2002; **37**: 802-804 [PMID: 11987107 DOI: 10.1053/jpsu.2002.32293]

10 **Evrengül H**, Yüksel S, Orpak S, Özhan B, Ağladıoğlu K. Chilaiditi Syndrome. *J Pediatr* 2016; **173**: 260 [PMID: 27016047 DOI: 10.1016/j.jpeds.2016.02.060]

11 **Dutt R**, Dutt C. Chilaiditi syndrome: a rare manifestation in newborn. *J Clin Neonatol* 2013; **2**: 50-51 [PMID: 24027748 DOI: 10.4103/2249-4847.109251]

12 **Ghani S**, Course CW, Bodla HP. From sign to syndrome: Chilaiditi. *Arch Dis Child* 2017; **102**: 1117 [PMID: 28756374 DOI: 10.1136/archdischild-2017-313467]

13 **Sunejam U**, Alharbi O, Karki K, Agyare S. Chilaiditi Syndrome. *Consult Pediatr* 2016; **15**

14 **Blevins WA**, Cafasso DE, Fernandez M, Edwards MJ. Minimally invasive colopexy for pediatric Chilaiditi syndrome. *J Pediatr Surg* 2011; **46**: e33-e35 [PMID: 21376185 DOI: 10.1016/j.jpedsurg.2010.11.039]

15 **Erdem SB**, Nacaroğlu HT, Karkıner CŞÜ, Alper H, Can D. Chilaiditi Syndrome in Two Cases Presented with Respiratory Distress Symptoms. *Turk Thorac J* 2015; **16**: 97-100 [PMID: 29404084 DOI: 10.5152/ttd.2014.4063]

16 **Hussain S**, Hussain S, Hussain S. Chilaiditi Syndrome-What's Air Doing There? *J Emerg Med* 2018; **55**: e131-e132 [PMID: 30181076 DOI: 10.1016/j.jemermed.2018.07.022]

17 **Ogasawara M**, Ishiyama A, Sugiura A, Segawa K, Nonaka I, Takeshita E, Shimizu-Motohashi Y, Komaki H, Sasaki M. Duchenne muscular dystrophy with platypnea-orthodeoxia from Chilaiditi syndrome. *Brain Dev* 2018; **40**: 339-342 [PMID: 29157800 DOI: 10.1016/j.braindev.2017.11.001]

18 **Inzamam Ali M**, El Essawy B, Menakuru S. Undiagnosed Chilaiditi syndrome presenting with pericarditis in a patient with congenital anomalies. *BMJ Case Rep* 2018; **2018** [PMID: 29970610 DOI: 10.1136/bcr-2018-225760]

19 **Fitzgerald JF**, Tronconi R, Morris LD, Nowicki MJ. Clinical quiz. Chilaiditi's sign. *J Pediatr Gastroenterol Nutr* 2000; **30**: 425, 471 [PMID: 10776955 DOI: 10.1097/00005176-200004000-00014]

20 **Bostancı İ**, Üner Ç, Erdoğan D. In the differential diagnosis of wheezy infant, Chilaiditi syndrome caused by empty bottle absorption. *J Contemp Med* 2019; **9**:410–1 [DOI: 10.16899/jcm.661326]

21 **Sinopidis X**, Gkentzi D, Kostopoulou E, Karatza A, Dimitriou G. Upgrade of Chilaiditi Sign to Syndrome: Are There Any Predisposing Factors? *J Emerg Med* 2019; **57**: 573-574 [PMID: 31739911 DOI: 10.1016/j.jemermed.2019.04.035]

22 **Flores N**, Ingar C, Sánchez J, Fernández J, Lazarte C, Málaga J, Medina M, Herrera R, Morales C. [The Chilaiditi syndrome and associated volvulus of the transverse colon]. *Rev Gastroenterol Peru* 2005; **25**: 279-284 [PMID: 16237473]

23 **Huang WC**, Teng CS, Tseng MH, Lin WJ, Wang CC. Chilaiditi's syndrome in children. *Acta Paediatr Taiwan* 2007; **48**: 77-83 [PMID: 17626607]

24 **Jackson AD**, Hodson CJ. Interposition of the colon between liver and diaphragm (Chilaiditi's syndrome) in children. *Arch Dis Child* 1957; **32**: 151-158 [PMID: 13425667 DOI: 10.1136/adc.32.162.151]

25 **Keles S**, Artac H, Reisli I, Alp H, Koc O. Chilaiditi syndrome as a cause of respiratory distress. *Eur J Pediatr* 2006; **165**: 367-369 [PMID: 16489467 DOI: 10.1007/s00431-005-0077-9]

26 **London D**, Sestopal-Epelman M, Lebovici O. Chilaiditi's syndrome in an infant: bowel loops mimicking mass lesions on sonography. *Pediatr Radiol* 1995; **25** Suppl 1: S238-S239 [PMID: 8577541]

27 **Pintér A**, Pilaszanovich I, Bakó M. Chilaiditi's syndrome--successful surgical correction. *Z Kinderchir Grenzgeb* 1980; **30**: 271-273 [PMID: 6778017 DOI: 10.1055/s-2008-1066370]

28 **Teng CS**, Lin WJ, Tseng MH, Wang CC. Chilaiditi's syndrome in a 9-year-old girl with hepato-diaphragmatic interposition of the colon: a short report. *Eur J Pediatr* 2005; **164**: 119-120 [PMID: 15703982 DOI: 10.1007/s00431-004-1574-y]

29 **Aldoss IT**, Abuzetun JY, Nusair M, Suker M, Porter J. Chilaiditi syndrome complicated by cecal perforation. *South Med J* 2009; **102**: 841-843 [PMID: 19593284 DOI: 10.1097/SMJ.0b013e3181ad5d62]

30 **Chinnappan K**, Abhyankar A, Jameel Z. Chilaiditi's syndrome with cecal volvulus and perforation. *Am Surg* 2008; **74**: 1220-1222 [PMID: 19097543]

31 **Altomare DF**, Rinaldi M, Petrolino M, Sallustio PL, Guglielmi A, Pannarale OC. Chilaiditi's syndrome. Successful surgical correction by colopexy. *Tech Coloproctol* 2001; **5**: 173-175 [PMID: 11875687 DOI: 10.1007/s101510100022]

32 **Nakagawa H**, Toda N, Taniguchi M, Ibukuro K, Tagawa K. Prevalence and sonographic detection of Chilaiditi's sign in cirrhotic patients without ascites. *AJR Am J Roentgenol* 2006; **187**: W589-W593 [PMID: 17114510 DOI: 10.2214/AJR.05.0597]

33 **Correa Jiménez O**, Buendía De Ávila M, Parra Montes E, Davidson Córdoba J, De Vivero Camacho R. [Chilaiditi’'s sign and syndrome: rare conditions but diagnostically important in pediatrics. Clinical cases]. *Rev Chil Pediatr* 2017; **88**: 635-639 [PMID: 29546949 DOI: 10.4067/S0370-41062017000500010]

**Footnotes**

**Informed consent statement:** Informed written consent was obtained from the patient for publication of this report and any accompanying images.

**Conflict-of-interest statement:** The authors declare that they have no conflict of interest.

**CARE Checklist (2016) statement:** The authors have read the CARE Checklist (2016), and the manuscript was prepared and revised according to the CARE Checklist (2016).

**Open-Access:** This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution NonCommercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/Licenses/by-nc/4.0/

**Manuscript source:** Invited manuscript

**Peer-review started:** January 5, 2021

**First decision:** January 25, 2021

**Article in press:**

**Specialty type:** Gastroenterology and hepatology

**Country/Territory of origin:** United States

**Peer-review report’s scientific quality classification**

Grade A (Excellent): 0

Grade B (Very good): 0

Grade C (Good): C

Grade D (Fair): 0

Grade E (Poor): 0

**P-Reviewer:** Raahave D **S-Editor:** Zhang L **L-Editor: P-Editor:**

**Figure Legends**



**Figure 1 Imaging of abdomen and pelvis of a 12-year-old male with Chilaiditi syndrome and constipation.** A: Computerize tomography. Marked air and fecal retention of the entire colon with colonic interposition above the liver with displacement of the liver leftwardly. This phenomenon indicates segmental agenesis of the right lobe of the liver and relaxation of the hepatic suspensory ligament; B: Plain X-ray. Markedly greater than average amount of fecal material particularly in the rectosigmoid colon. Few air fluid levels in the distal small bowel and air filled colonic loops that reach the right hemidiaphragm.

**Table 1 Case series of Chilaiditi syndrome in the pediatric population**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Ref.** | **Sex** | **Age** | **Predisposition** | **Bowel segment** | **Symptoms** | **Type of interposition** | **Dx Procedure** | **Treatment** | **Type of surgery** | **Outcome** |
| [24] | M | 16 mo | Aerophagia | Colon | Abdominal distention and pain, vomiting | Complete | KUB | Conservative | --- | Resolution |
| [24] | F | 3 yr | Aerophagia | Colon | Abdominal Distention and pain, passed flatus | Complete | KUB | Conservative | --- | Resolution |
| [24] | F | 5 yr | Aerophagia, Constipation | Colon | Abdominal pain, constipation | Partial | KUB | Conservative | --- | Resolution |
| [24] | F | 4 yr | Aerophagia | Colon | Anorexia, recurrent abdominal pain, vomiting | Complete | KUB | Conservative | --- | Resolution |
| [27] | F | 2 yr | --- | Colon | Marasmus, vomiting, lethargy, inability to walk | Complete | KUB | Surgery (Volvulus) | Laparoscopic Colopexy and Transverse Colectomy | Resolution |
| [26] | M | 6 mo | --- | Colon | Abdominal pain, vomiting | Partial | KUB | Conservative | --- | Resolution |
| [19] | M | 8 yr | Aerophagia | Colon | Abdominal pain, distention | Complete | KUB | Conservative | --- | Resolution |
| [7] | M | 12 yr | --- | Colon | Respiratory distress, pleuritic pain, fever | Complete | CXR, BE | Surgical (Volvulus) | Laparoscopic Detorsion | Resolution |
| [22] | M | 17 yr | Mental Retardation, Constipation, Congenital Adhesions | Colon | Abdominal distention, vomiting, constipation | Complete | CXR, KUB | Surgical (Volvulus) | Laparoscopic Transverse Colectomy | Resolution |
| [28] | F | 9 yr | Constipation | Colon | Abdominal pain, nausea, constipation | Complete | CXR, KUB | Conservative | --- | Resolution |
| [9] | F | 11 yr | Constipation | Colon | Abdominal pain, vomiting | Complete | KUB, CT | Surgery | Laparoscopic Transverse Colectomy | Resolution |
| [23] | F | 9 yr | DE, Constipation | Colon | Epigastric pain, constipation, nausea | Complete | CXR, KUB, CT | Conservative | --- | Resolution |
| [23] | M | 1 yr | DE | Colon | Recurrent respiratory distress | Complete | CXR, KUB, CT | Surgery | Correction of Diaphragmatic, Eventration and Elevation of Right Hemidiaphragm | Resolution |
| [23] | F | 16 mo | DE | Colon | Recurrent respiratory distress | Complete | CXR, KUB, CT | Surgery | Correction of Diaphragmatic, Eventration and Elevation of Right Hemidiaphragm | Resolution |
| [25] | M | 5 mo | --- | Colon | Recurrent respiratory distress | Complete | CXR, CT | Conservative | --- | Resolution |
|  Present study | M | 12 yr | Constipation | Colon | Recurrent respiratory distress, abdominal pain, constipation | Complete | CXR, KUB | Surgical | Laparoscopic Colopexy | Resolution |
| [33] | F | 2 yr | Constipation | Colon  | Recurrent respiratory distress, abdominal pain, constipation | Complete | CXR | Conservative | --- | Resolution |
| [10] | M | 8 yr | Constipation | Colon  | Abdominal pain, constipation | Complete | KUB, CT | Conservative | --- | Resolution |
| [11] | M | 10 d |  Constipation | Colon | Abdominal distension, respiratory distress, constipation | Complete | KUB | Conservative | --- | Resolution |
| [12] | F | 3 yr | Constipation | Colon | Recurrent respiratory distress, constipation | Complete | CXR | Conservative | --- | --- |
| [13] | M | 4 yr | Aerophagia | Colon | Respiratory distress | Complete | CXR | Conservative | --- | Resolution |
| [14] | M | 6 yr | --- | Colon | Abdominal pain, emesis, FTT | Complete | CXR | Surgical | Laparoscopic Colopexy | Resolution |
| [15] | M | 10 yr | Aerophagia | Colon | Recurrent respiratory distress | Complete | CXR, MRI | Conservative | --- | Resolution |
| [15] | M | 7 yr | Aerophagia | Colon | Recurrent respiratory distress, abdominal distention | Complete | CXR, MRI | Conservative | --- | Resolution |
| [8] | M | 4 yr | Aerophagia, Constipation | Colon | Recurrent respiratory distress, abdominal pain, constipation | Complete | CXR, CT | Conservative | --- | Resolution |
| [16] | M | 3 yr | Aerophagia | Colon | Recurrent respiratory distress, abdominal distention | Complete | CXR | Conservative | --- | Resolution |
| [17] | M | 20 yr | Duchenne Muscular | Colon | Recurrent respiratory distress | Complete | CT | Conservative | --- | Resolution |
| [18] | M | 19 yr | Dystrophy, Aerophagia, Constipation  | Colon | Chest pain, respiratory distress, abdominal pain | Complete | CXR | Conservative | --- | Resolution |
| [20] | F | 1 yr | Aerophagia | Colon | Respiratory distress | Partial | CXR | Conservative | --- | Resolution |
| [21] | M | 10 yr | Constipation, Mental Retardation | Colon | Respiratory distress, constipation, failure to thrive, abdominal distention | Complete | CXR | --- | --- | --- |

BE: Barium Enema; CT: Computerized tomography; CXR: Chest X-Ray; DE: Diaphragmatic eventration; KUB: Kidney, Ureter, and Bladder X-Ray; MRI: Magnetic resonance imaging.