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1 **ABSTRACT**

2

3 **Objectives:** To report the prevalence of abnormal fluoroscopic findings in
4 brachycephalic dogs presenting to a referral hospital for obstructive airway
5 syndrome.

6

7 **Methods:** Hospital records between May 2013 and November 2015 identified 36
8 brachycephalic dogs investigated for obstructive airway disease: 21 French
9 bulldogs, 6 bulldogs, 4 Boston terriers, 2 pugs, 2 boxers and 1 shih tzu. The
10 presence or absence of hiatal hernia, delayed oesophageal transit, gastro-
11 oesophageal reflux, and redundant oesophagus were recorded.

12

13 **Results:** 16 dogs had hiatal hernia, all of which were French Bulldogs. 31 dogs
14 had delayed oesophageal transit time, 27 had gastro-oesophageal reflux and 4
15 had redundant oesophagus.

16

17 **Clinical Significance:** The prevalence of hiatal hernia is higher than expected in
18 the French bulldog and there was a high prevalence of oesophageal disease in
19 this group in general. These results suggest a need to investigate similar cases
20 for evidence of gastrointestinal disease that may also require attention.

21

22 **Keywords:** Fluoroscopy, brachycephalic, hiatal hernia

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30 **INTRODUCTION**

31 The oesophageal hiatus lies between the diaphragmatic crura and transmits the
32 oesophagus, its vascular supply and the dorsal and ventral vagus trunks. It has a
33 thicker muscular border compared to the rest of the diaphragm. (Evans *et al.*,
34 2012).

35

36 Hiatal hernia is defined as the protrusion or displacement of abdominal organs or
37 structures through the oesophageal hiatus into the mediastinum. Four types of
38 hiatal hernia have been documented in dogs. Type I (sliding hiatal hernia) occurs
39 when the abdominal oesophagus and part of the stomach displace cranially
40 through the oesophageal hiatus resulting in the gastro-oesophageal junction lying
41 within the thoracic cavity. (Rahal *et al.*, 2003). Type II is defined as a
42 paraoesophageal hernia in which the caudal oesophageal sphincter remains in
43 place at the hiatus and part of the stomach herniates adjacent to this into the
44 mediastinum. Type III has characteristics of both type I and II with concurrent
45 axial and paraoesophageal herniation. (Williams, 1990). Type IV has only been
46 reported once and is similar to type II or III but involves other organs (liver,
47 stomach, small intestine) herniating adjacent to the oesophagus (Washabau,
48 2012). The type 1 sliding hiatal hernia is the most common form documented in
49 dogs. (Llabres-Diaz *et al.*, 2008)

50

51 Hiatal hernias may be either congenital or acquired. Congenital hernias have
52 previously been reported in the Chinese shar pei, bulldog, French bulldog and
53 chow chow breeds. (Callan *et al.*, 1993), (Washabau, 2005), (Poncet *et al.*,
54 2005), (Cornell, 2011), (Washabau, 2012). Congenital hernias occur due to a
55 developmental abnormality of the oesophageal hiatus or phrenicoesophageal
56 ligament. (Jergens, 2010). This then allows cranial displacement of abdominal
57 structures into the thorax as described above.

58

59 There is relatively scant information within the veterinary literature regarding
60 acquired hiatal hernias; they have been reported secondary to diaphragmatic
61 repair, trauma, an oesophageal or upper respiratory tract disease or a
62 neuromuscular disorder. (Llabres-Diaz *et al.*, 2008). In human medicine one
63 widely accepted theory is that an abnormal increase in abdominal pressure
64 increases the pressure gradient between the abdominal and thoracic cavities
65 resulting in the displacement or “pushing up” of the gastro-oesophageal junction
66 through a normal hiatus. There is no supporting experimental evidence for this
67 theory despite its wide acceptance. (Christensen *et al.*, 2000).

68

69 This pressure differential is compounded when combined with an abnormal
70 inspiratory effort, resulting in abnormally low intrathoracic pressure, and has
71 been proposed as sufficient to induce a hiatal hernia. (Bright *et al.*, 1990),
72 (Lecoindre *et al.*, 2004), (Pratschke *et al.*, 1998), (Sivacolundhu *et al.*, 2002). A
73 hiatal hernia has been documented in cases of abnormal respiratory effort such
74 as laryngeal paralysis and following repair of chronic diaphragmatic hernia.
75 (Bright *et al.*, 1990), (Pratschke *et al.*, 1998).

76

77 Documented sequelae to chronic hiatal hernia includes gastro-oesophageal reflux
78 which allows either ingesta or fluid from the stomach to pass retrogradely into the
79 oesophagus. Oesophagitis is a common sequela because of exposure to gastric
80 acid, pepsin, trypsin, bile salts and duodenal bicarbonate and may in turn lead to
81 reduced oesophageal motility and, in severe cases, oesophageal stricture. The
82 severity of the oesophagitis will relate to the frequency and content of the reflux.
83 (Washabau, 2012). It is therefore advantageous to diagnose and manage cases
84 as early as possible.

85

86 Diagnosis of a hiatal hernia may occasionally be made on plain radiography;
87 radiographic findings include identification of a rounded soft tissue opacity or gas

88 filled viscus in the caudodorsal thorax overlying the diaphragm. This diagnosis
89 may be aided with barium contrast radiography which makes the delineation of
90 the gastric and oesophageal margins clearer. Videofluoroscopy is more useful
91 than plain radiography in cases in which the hernia is intermittent and can also be
92 used to document gastro-oesophageal reflux, hypomotility and oesophageal
93 redundancy, (Washabau, 2005), (Cornell, 2011), (Washabau, 2012), (Llabres-
94 Diaz *et al.*, 2008). Endoscopy may document concurrent oesophagitis, gastro-
95 oesophageal reflux and findings consistent with a hiatal hernia such as cranial
96 displacement of the caudal oesophageal sphincter and a large oesophageal hiatus
97 (Washabau, 2005; Cornell, 2011). However, recently it has been suggested that
98 endoscopy may fail to diagnose some cases of gastro-oesophageal junction
99 disorders because of the effects of endotracheal intubation and anaesthesia
100 (Vangrinsven *et al.*, 2015). This study also demonstrated that obstruction of the
101 endotracheal (ET) tube improves the detection of abnormalities of the gastro-
102 oesophageal junction. Detection can be improved by using fluoroscopy in fully
103 conscious animals in which there will be normal airway pressures and provides
104 valuable information for the likelihood of reflux in brachycephalic patients with
105 increased risk at general anaesthesia. (Brodbelt *et al.*, 2008)

106

107 The aim of this current study is to report the prevalence of hiatal hernia in
108 brachycephalic breeds presenting to referral hospital for treatment of
109 brachycephalic obstructive airway syndrome (BOAS).

110

111 **MATERIALS AND METHODS**

112 Diagnostic imaging records of fluoroscopy barium swallow studies performed on
113 brachycephalic breed dogs at Small Animal Hospital Langford Vets, University of
114 Bristol over a retrospective 30-month period between May 2013 and November
115 2015 were selected for review.

116

117 The routine protocol for a barium swallow study was as follows: i) the dog stands
118 with food placed in front of them in a raised food bowl; ii) room temperature food
119 coated in barium sulphate powder (Vet-Way Ltd) or 5ml Iohexol 300mg I/ml
120 (Omnipaque, GE Healthcare) was offered; iii) dogs were offered soft food and
121 kibble on separate occasions; the amount and specific brand of each food type
122 was varied and tailored to patient appetite.

123

124 The food boluses were tracked from the oropharynx through to the stomach using
125 videofluoroscopy with a frame rate of 8 frames per second. Assessment of oral,
126 pharyngeal, oesophageal and gastro-oesophageal phases were included. In all
127 studies routine application of pressure to the abdomen using paddles was applied
128 if no hiatal hernia was documented on the initial images. This application of
129 pressure was done immediately prior to screening; in order to comply with
130 radiation safety this was only done if the person applying pressure was safely
131 away from the primary beam. Two observers were always present: a
132 radiographer and a radiologist (either a radiology resident or a board-certified
133 diplomate). Video loops were saved for further review.

134

135 The videofluoroscopy studies for all of the patients were reviewed using
136 proprietary software (Visbion Image Viewer, Visbion, Chertsey, Surrey, UK) by 2
137 reviewers: 1 board-certified radiologist (CWS) and 1 second year radiology
138 resident (LR) The studies were reviewed with no knowledge of the signalment,
139 presenting complaint or original study diagnosis. Agreement by consensus was
140 reached for every patient. The original reports of the fluoroscopy studies were
141 later reviewed to determine whether abdominal pressure had been used to
142 identify a hiatal hernia.

143

144 Studies were assessed for the presence of a hiatal hernia, oesophageal
145 redundancy, gastro-oesophageal reflux and poor oesophageal motility. These

146 were defined as follows (following Gaschen, 2012). *Hiatal hernia* was diagnosed if
147 any portion of the stomach (usually the fundus) protruded cranial to the
148 diaphragm accompanied by cranial movement of the remainder of the stomach
149 towards the diaphragm. This is detected on videofluoroscopy by seeing the soft
150 tissue opacity wall of the stomach as a separate structure located within the
151 thorax cranial to the diaphragmatic crura at a level between the aorta and the
152 caudal vena cava. *Gastro-oesophageal reflux* was defined as retrograde motion of
153 the positive contrast-soaked ingesta from the stomach to the oesophagus. *Poor*
154 *motility* was defined as failure of the bolus to progress smoothly and rapidly along
155 the oesophagus due to either bolus retention at any location in the oesophagus
156 after more than 2 subsequent swallow attempts, retrograde movement of the
157 bolus of greater than 10 cm, or increased transit time defined as more than 10 s.
158 *Oesophageal redundancy* was defined as a focal dilation of increased diameter or
159 distension of the oesophagus cranial to, or at the level of, the thoracic inlet. This
160 was delineated during videofluoroscopy study with focal accumulation of the
161 positive contrast medium-soaked food.

162

163 **RESULTS**

164 Forty-one fluoroscopy barium swallow studies were identified, of 41 different
165 dogs. The studies were graded as adequate or poor quality. Four studies were
166 graded as being of poor quality due to reluctance or refusal to eat or too much
167 movement of the patient, all such studies were discarded. Additionally, 1 study
168 was discarded because it was not available for review. Three studies had required
169 a repeat attempt either later the same day or on a different date to obtain a
170 diagnostic quality fluoroscopy barium swallow. In all, therefore, 36 dogs met the
171 inclusion criteria.

172

173 The breed, age and gender of the dogs are presented in Table 1. The findings
174 from the study included delayed oesophageal transit time or reduced oesophageal

175 motility, gastro-oesophageal reflux, hiatal hernia, and a redundant oesophagus,
176 are also presented in Table 1.
177 For all cases the concurrent gastro-intestinal symptoms were chronic
178 regurgitation of food, water, or both. This was most often reported to occur either
179 during, or immediately after, exercise. Occasionally there were reports of
180 intermittent vomiting in addition to regurgitation. Case 2 additionally had
181 episodes of nasal discharge which were presumed most likely to be due to
182 regurgitation into the nasopharynx, although this patient only had findings of
183 delayed transit on the fluoroscopy study. For the dogs that had presented for a
184 fluoroscopy study primarily for gastroesophageal disease (Cases 1, 5, 7, 9, 10,
185 and 36), 5 were due to the primary clinical complaint of regurgitation and
186 vomiting, 1 (Case 5, boxer) was investigated because of concurrent myositis and
187 concern for oesophageal dysmotility.

188 (Insert table 1)

189

190 Of the 36 dogs, 16 had hiatal hernias, all of which were French bulldogs, 1 of
191 these (Case 6) had abdominal compression used, the others demonstrated a
192 hernia without the need to apply compression. Thirty-one had delayed
193 oesophageal transit time, 27 had gastro-oesophageal reflux and 4 had redundant
194 oesophagus (which, when present, was seen at the thoracic inlet in all cases).
195 Nearly all of the dogs demonstrated more than one abnormality. (See Table 1).
196 14/16 dogs with hiatal hernias had concurrent evidence of gastro-oesophageal
197 reflux seen on fluoroscopy.

198 Insert figures 1A, 1B and 2

199

200 **DISCUSSION**

201 The results of this study suggest that hiatal hernia is common in brachycephalic
202 dogs that present primarily with clinical signs of brachycephalic obstructive airway
203 disease and that the prevalence is higher than has previously been reported.

204 Congenital hernias have previously been reported in the Chinese shar pei,
205 bulldog, French bulldog and chow chow breeds. (Callan *et al.*, 1993), Washabau,
206 2005), (Cornell, 2011), (Poncet *et al.*, 2005), (Washabau, 2012). However many
207 of the previous studies suggesting possible breed predisposition were based on
208 very small numbers of dogs (n=7) or are individual case reports (n=2) A case
209 study in 2005 documented only 20 previous reports of sliding hiatal hernias in the
210 veterinary literature (Kirkby *et al.*, 2005).

211

212 It is known that many BOAS-affected dogs have gastrointestinal signs, and the
213 majority (30/36) of the brachycephalic dogs in this study primarily presented for
214 surgical treatment of obstructive airway disease because of typical clinical signs,
215 such as upper respiratory obstruction, collapse, exercise intolerance or inability to
216 cope with heat or stressful events. They were not referred for a gastrointestinal
217 disorder but, during history taking, there was evidence of gastrointestinal disease
218 in each case. This was most commonly regurgitation, often during or after
219 exercise, and therefore a fluoroscopy swallowing study was indicated. A previous
220 study of brachycephalic dogs presenting for respiratory signs demonstrated a
221 97.3% prevalence of gastrointestinal tract clinical findings including oesophageal
222 deviation, distal oesophagitis, gastro-oesophageal reflux, hiatal hernia, gastritis,
223 and duodenitis based on clinical evaluation, endoscopic and histologic
224 examination (Poncet *et al.*, 2005). It also documented a significant relationship
225 between the severity of the respiratory and digestive signs for 3 of their
226 independent variables: French Bulldogs, males and heavy brachycephalic dogs..
227 A second study revealed improvement in gastrointestinal disorders following
228 upper respiratory tract surgery and gastrointestinal medical management in
229 91.4% of 51 dogs. (Poncet *et al.*, 2006).

230

231 Poncet *et al.* (2005) described 73 dogs, of which 49 were French bulldogs of which
232 only 3 were found to have a hiatal hernia (6%). Poncet *et al.* (2006) concerned 61

233 dogs, of which only 2 of 42 French bulldogs were diagnosed with hiatal hernia
234 (5%). Neither of these studies used fluoroscopy as a diagnostic test for hiatal
235 hernia. It appears possible that these 2 studies may have under estimated the
236 prevalence of the condition in this brachycephalic breed based on comparison
237 with the results we report here (16/21 [76%] French bulldogs diagnosed with
238 hiatal hernia).

239

240 The most common findings in the current group of dogs were delayed
241 oesophageal transit time (31 of 36 dogs) and gastroesophageal reflux (27 of 36
242 dogs). Normal swallowing is a combined voluntary and reflex action which, once
243 initiated, should propel food to the stomach via 3 phases. The initial oral
244 voluntary phase is bolus formation and presentation to the pharynx. The second
245 pharyngeal phase is the initiation of the reflex swallow. The soft palate is pulled
246 dorsally and the palatopharyngeal folds medially, the epiglottis moves forward to
247 cover the larynx and the cranial oesophageal sphincter relaxes. The food is
248 propelled to the oesophagus due to forcible constriction of the dorsal pharyngeal
249 muscles. This second phase should occur in less than 1 second. The third phase,
250 also involuntary and under partial control of the swallowing centre, is constriction
251 of the cranial oesophageal sphincter after the bolus has passed, followed by
252 initiation of a primary peristaltic wave which should traverse the oesophagus in
253 10 seconds. If this is insufficient to propel the bolus to the stomach a secondary
254 peristaltic wave is initiated. During the primary peristaltic wave the caudal
255 oesophageal sphincter will relax allowing food to enter the stomach and should
256 constrict after passage of the food. (Gengler, 2010).

257

258 Delayed oesophageal transit time is a result of a reduced coordination or poor
259 bolus passage. A delayed maturation of the oesophagus has been proposed as a
260 mechanism for delayed oesophageal transit time in dogs under 1 year of age.
261 (Bexfield *et al.*, 2006). In the current study 6 dogs were under 1 year of age, but

262 only 4 of these displayed delayed transit. The remaining 27 dogs with delayed
263 transit were over 1 year old, therefore delayed maturation must be considered an
264 unlikely cause of reduced motility. Additionally, in the current study 2 of the 4
265 dogs under 1 year of age with delayed transit also had a hiatal hernia, which is
266 always an abnormal finding.

267

268 The 2 boxers were older (72 and 116 months) than the majority of the other
269 included dogs, and also had additional presenting signs: 1 had generalised
270 weakness and the other had diarrhoea in addition to regurgitation. Therefore,
271 although they were included within our retrospective search criteria, they would
272 be unlikely to have the same pathophysiology of hiatal hernia development
273 compared to the other individuals.

274

275 The identification of reflux and regurgitation is important because it increases risk
276 of post-operative aspiration, which is already an increased risk in dogs
277 undergoing upper airway surgery. (Ovbey *et al.*, 2014), (Davies *et al.*, 2015).
278 Therefore prior knowledge regarding the severity of oesophageal disease could
279 allow for improved assessment of anaesthetic risk.

280

281 There are no reports in the veterinary literature regarding the relative
282 sensitivities and specificities of each diagnostic modality for hiatal hernia. This
283 may be in part due to the fact that a gold standard diagnosis at surgery or *post*
284 *mortem* is infrequently achieved. Given the intermittent nature of the sliding
285 hiatal hernia we would support previous statements that fluoroscopy during
286 feeding of a barium meal is more sensitive than radiography. However small
287 hiatal hernias are still likely to be overlooked due to superimposition of other
288 structures (Kahrilas *et al.*, 2008). The sensitivity of fluoroscopy in humans for
289 diagnosis of hiatal hernia is improved when abdominal pressure is increased
290 during the examination (normally in the form of the Valsalva manoeuvre) and we

291 have found that increasing intra-abdominal pressure using paddles or hands
292 either side of the abdomen immediately prior to fluoroscopic image acquisition
293 can aid recognition of herniation in dogs. The application of abdominal pressure is
294 not a technique that has been validated in the veterinary literature and is
295 performed at our institution only if a hiatal hernia has not been seen already. Due
296 to the retrospective nature of this study in the cases in which abdominal pressure
297 was used, it was not possible to determine which dogs demonstrated a hiatal
298 hernia after increased abdominal pressure but not before. However, the use of
299 paddles was recorded, and only 1 dog found to have a hiatal hernia was
300 diagnosed subsequent to their use. Given that only 1 of the dogs with a hiatal
301 hernia required the use of paddles the technique, although historically used if a
302 hernia has not been seen at the authors institution, may be less rewarding than
303 we had previously perceived. Similar comments regarding the variability of the
304 usefulness of increasing the abdominal pressure to diagnose a hernia is
305 mentioned in previous literature. (Suter *et al.*, 1984).

306

307 It is also notable that, being often intermittent in nature, hiatal hernia may occur
308 but not be detected during a study, especially in non-cooperative subjects. It can
309 therefore be assumed that our estimation of the prevalence may also likely be an
310 underestimate. We find a short duration of starvation, such as 12 hours prior to
311 the procedure, improves the likelihood of patient cooperation and eating for the
312 fluoroscopy study as does the use of a food type familiar to the patient. The
313 radiation dose to personnel must be considered and the correct personal radiation
314 protection and safety measures taken. A disadvantage of fluoroscopy as a
315 diagnostic test is the availability and cost of equipment, which is often only
316 available in referral centres.

317

318 Endoscopy has the advantage that it does not involve ionising radiation but it
319 requires anaesthesia and, in human medicine, there are documented difficulties in

320 diagnosing hiatal hernia due to the difficulty in precisely locating the
321 diaphragmatic crura. Additionally insufflation of the stomach may artificially
322 increase the size of a hernia. (Kahrilas *et al.*, 2008). It is possible that in
323 comparison to the Poncet *et al* 2005 and 2006 reports the higher prevalence of
324 hiatal hernias noted in the current study may be in part related to the use of
325 fluoroscopy rather than endoscopy for diagnosis.

326

327 In humans, manometry has also been used to assess the spatial and topographic
328 pressure profiles of the diaphragm and the gastro-oesophageal junction. In
329 comparison with endoscopy, manometry had a significantly higher specificity but
330 both modalities had high proportion of false negatives for diagnosis of sliding
331 hiatal hernia (Khajanchee *et al.*, 2013). Manometry has been performed in dogs
332 and is possible without sedation, but the procedure was reported in
333 mesaticephalic dogs, and there are currently no known reference values (Kempf
334 *et al.*, 2013). Recent work has also shown that the prevalence of hiatal hernias
335 diagnosed during endoscopy is likely artefactually low due to the effects of
336 anaesthesia and intubation mainly because endotracheal intubation negates the
337 pressure changes associated with brachycephalic airway disease (Vangrinsven *et*
338 *al.*, 2015).

339

340 In conclusion, we propose that the prevalence of oesophageal disease and,
341 particularly, the prevalence of hiatal hernia is higher than previously documented
342 in brachycephalic dogs presenting with BOAS, especially in French bulldogs. This
343 is clinically relevant because recognition of the hiatal hernia and oesophageal
344 disease, with appropriate management of secondary oesophagitis, is of benefit to
345 reduce the anaesthesia risk. Further studies are warranted to determine if the
346 prevalence or severity of hiatal hernia is reduced following correction of the
347 obstructive airway syndrome.

348

349 **No conflicts of interest have been declared.**

350

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440

441 **Table 1 legend:**

442 Summary table of results displaying the breed, age, gender and fluoroscopic
443 barium swallow findings.

444 § This dog was the only one in which the hernia was demonstrated with the use
445 of paddles. All other hiatal hernia were noted without artificially increasing
446 abdominal pressure.

447 * These 6 dogs presented for regurgitation, recurrent or intermittent vomiting. All
448 the other 30 patients presented primarily for BOAS.

449

450 **Figure 1 legend:**

451 Figure 1 are fluoroscopy still frame images of the liquid contrast phase in a dog
452 that had a moderate sized hiatal hernia, oesophageal reflux and poor motility.

453 1A: the stomach is in a normal position, caudal to the diaphragm, and contains
454 liquid positive contrast medium. 1B shows cranial displacement of the
455 gastroesophageal junction into the thorax.

456

457 **Figure 2 legend:**

458 Figure 2 shows a moderate-sized hiatal hernia, demonstrating displacement of
459 the gastroesophageal junction into the thorax, with the cardia of the stomach

460 containing gas and positive contrast-soaked kibble clearly visible cranial to the
461 diaphragm.