An 82-year-old man was referred to our clinic for cardiac evaluation before inguinal hernia repair surgery. His previous medical history revealed hypertension and coronary artery disease. The patient was asymptomatic, and his physical examination was unremarkable. A 12-lead electrocardiography demonstrated normal sinus rhythm with first-degree atrioventricular block. Transthoracic echocardiography (TTE) showed regional wall motion abnormalities and left ventricular ejection fraction was 50% as assessed by the Simpson’s method. Additionally, TTE parasternal long axis view, apical four-chamber view and apical long axis view demonstrated compression of the left atrium by an extrinsic, hyperechoic mass (Figure 1a-c). Thoracic computed tomography revealed a large sliding type hiatus hernia with intrathoracic extension to the posterior mediastinum and compression of left atrium from the posterior aspect (Figure 1d, e).

Hiatal hernia is defined as the protrusion of an organ, typically the stomach, from abdomen to thorax through the esophageal hiatus in the diaphragm and is usually associated with symptoms of gastroesophageal reflux disease.[1] Rarely, large hiatal hernias may lead to cardiac symptoms and complications such as dyspnea and exercise impairment, recurrent acute heart failure, angina-like chest pain and electrocardiographic changes due to its mechanical compression.[2-5] In some cases, hiatal hernia may mimic a left atrial mass and is diagnosed incidentally on TTE.[6]

**Declaration of conflicting interests**
The authors declared no conflicts of interest with respect to the authorship and/or publication of this article.

**Funding**
The authors received no financial support for the research and/or authorship of this article.

**REFERENCES**