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Case Report Open Access

Achalasia: A Puzzle that Remains Unsolved

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Abstract

A young male with achalasia underwent laparoscopic Heller's cardiomyotomy but two years later he presents again with the same symptoms. These symptoms in our very young patient do affect his quality of life but the available invasive treatment options are only palliative and aimed at relieving the severe symptoms only. With this case presentation, an effort is made to highlight the unpredictability of the available treatment options in terms of long-term outcome and the degree of improvement in a patient's quality of life. There is a dire need to better understand the pathophysiology of this condition in order to extrapolate this knowledge to better preventive and curative strategies. This case report also includes an extensive review of articles hypothesizing the etiology of achalasia.

Keywords: Esophageal motility disorder; Achalasia; Functional bowel disorder

Case presentation

A 20 year old male presented with the chief complaints of difficulty swallowing, regurgitation of food in the night and occasional chest pain for the past one year. He described the chest pain as heart burn that would come unprovoked, last for a few minutes and resolve on its own. The pain was occasionally very severe and stabbing, and it had started affecting his day-to-day life. The dysphagia symptoms started when he noticed that he could not swallow solids properly without sitting up straight. The food seemed to get stuck in the esophagus requiring him to drink lots of water 'to push it down' and it would regurgitate up easily on lying down. All the symptoms seemed to have exacerbated in the past 3 months and the dysphagia now included swallowing of liquids. A fast eater as a child, he had now started eating very slowly and scarcely. His biggest concern was the frequent episodes in the night when he would wakeup coughing, choking and vomiting food particles. Being scared of sleeping supine, he had started sleeping with the head end raised by a stack of pillows. His past history was positive for varicella infection as a child. There was no family history of similar conditions. On examination, he had normal vitals and the physical examination was unremarkable. A diagnosis of achalasia was suspected and barium swallow done subsequently showed moderate dilatation of lower half of the esophagus with smooth narrowing at the gastro-esophageal junction (classic bird's beak sign), few tertiary contractions during the passage of barium, no evidence of extrinsic compression and maintained mucosal pattern (Figures 1,2). High-resolution manometry showed increased lower esophageal sphincter (LES) basal pressure of 47.4mm of Hg (achalasia>45mm of Hg) and a median swallow-induced nadir of 16mm of Hg. It revealed in complete relaxation of LES and simultaneous, non-transmitted, mirror image contractions in distal

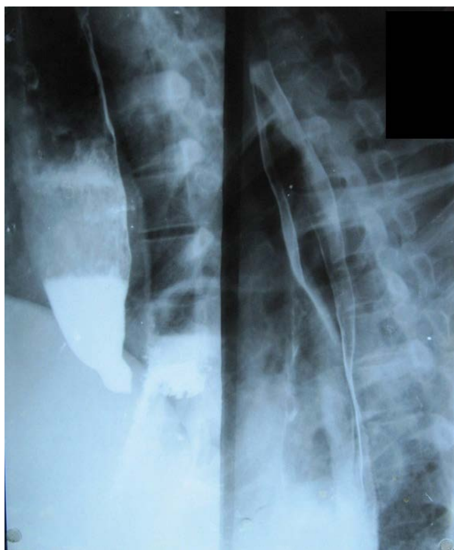

Figure 1: X-ray barium swallow showing dilatation of lower half of the esophagus with smooth narrowing at the gastro-esophageal junction (classic bird's beak sign) and air-fluid level.

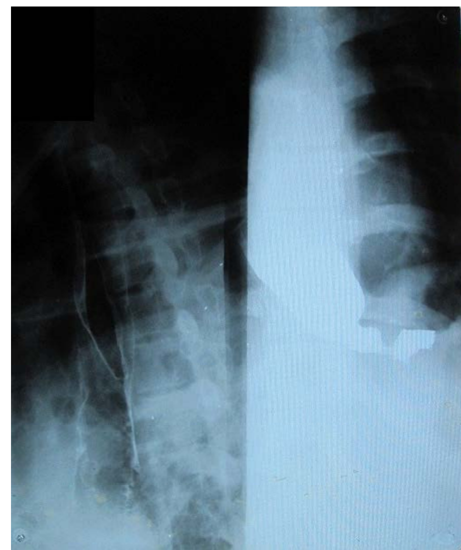

Figure 2: X-ray barium- swallow showing the narrowed gastro-esophageal junction and tertiary contractions.

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