



Case Reports

Achalasia Cardia – Case Report

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Abstract

A 45 years old man was admitted in the surgery unit-II at Rajshahi Medical College Hospital with the complaints of prolonged dysphagia and regurgitation of food and saliva. The patient had some weight loss but no anorexia, Barium swallow oesophagus showed marked dilatation of oesophagus with regular tapering of its lower end. The patient was diagnosed as achalasia cardia and underwent oesophago-cardio-myotomy operation. The patient relieved from his symptoms. He was followed up for 1 year and found healthy.

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Introduction

Achalasia cardia is a primary motility disorder of the oesophagus due to loss or reduction of ganglionic cells in the Auerbach's plexus. Hereditary, degenerative, autoimmune and infectious factors are possible causes of achalasia, the later two being the most commonly accepted possible aetiology.^{1, 2} Loss of ganglion cells result in failure of integration of the parasympathetic impulses so that oesophageal peristalsis is disorganized and there is failure of relaxation of cardiac end of oesophagus in response to swallowing.

The diagnosis of achalasia should be suspected if any one complains of progressive dysphagia for solid and liquid with regurgitation of food and saliva. The clinical suspicion should be established by a barium oesophagram. Oesophageal pressure manometry establishes the diagnosis showing pressure in the gastro-oesophageal junction is about twice normal (40 mm of Hg) and relaxation after swallowing is incomplete or absent.³

All patients should undergo upper gastro intestinal endoscopy to exclude pseudoachalasia arising from a tumour at gastro-oesophageal junction.⁴ There is no cure for achalasia, the goal of treatment is relief of patients symptoms and to improve esophageal emptying. The most two effective treatment options are graded pneumatic dilatation and seromyotomy either or laparoscopic procedure.

Here is a report of a case of achalasia cardia, which underwent seromyotomy and shows excellent postoperative symptomatic improvement.

Case history

Mr., a man of 45 years hailing from Paba thana of Rajshahi district was admitted into Rajshahi Medical College Hospital in surgery unit-II with the complaints of dysphagia for 8 years and regurgitation of food and saliva for 2 months. Although the dysphagia for solid started 8 years back but during presentation the patient had dysphagia for both solid and liquid food. With the

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progression of the disease the patient regurgitated undigested, retained food and accumulated saliva for the last 2 months. The patient had history of some weight loss but no anorexia, no previous history of corrosive ingestion or instrumentation. He was non-smoker and non-alcoholic. Physical examinations of the patient reveal no abnormality except mild anaemia.

The patient was suspected as a case of achalasia cardia. Barium oesophagram was done and showed marked dilatation of oesophagus proximal to obstruction with smooth wall and regular, smooth tapering all the lower end.

The patient was treated by oesophago-cardiomyotomy operation through abdominal approach. His postoperative recovery was excellent. The patient was followed up for 1 year and showed complete recovery from symptoms.



Fig-1: X-Ray Barium swallow before operation



Fig-2: X-Ray Ba swallow after operation.

Discussion

Achalasia of the oesophagus was first described by Hannary in 1933. Mikulica explained it is being due to spasm of cardiac sphincter but dissection showed no anatomical sphincter at this point. Achalasia cardia is a relatively well understood motility disorder of esophagus. The disease is common in middle life but can occur at any age even in infancy.⁵

The onset is insidious and more often the patient seeks attention after presenting the symptoms for many years.⁶

The most common symptoms are initial dysphagia to solid and subsequently both solid and liquid, regurgitation and chest pain. Although the dysphagia may initially be to solid only as many as 70-97% of the patients with achalasia develop dysphagia to solid and liquid at presentation.²

Regurgitation of food and saliva are usually present with the progression of the disease.

A barium swallow oesophagus is the single best diagnostic study when achalasia cardia is suspected. Dilatation and tortuosity of proximal oesophagus with smooth tapering at lower end resembling a sharpened wooden pencil tip appearance is characteristic.

Among motility disorder only achalasia cardia responds well to treatment.⁶ The two main methods are forceful dilatation of cardia and Heller's myotomy either open or laparoscopic procedure. Surgical myotomy involves a single anteriorly placed incision made through the serous layer, longitudinal and circular muscle fibers of oesophagus up to mucosa. The incision should be limited distally 1 cm from gastro-oesophageal junction to reduce post procedure reflux. It is not necessary to extend the cut for a long distance proximally as the purpose at operation is to weaken the sphincter alone.⁶ The results from published studies using either abdominal or thoracic approach showed symptomatic improvement upto 83% in a mean follow up time

of 7 years.¹ The main late complication of this procedure is gastro-oesophageal reflux. Here our patient was followed upto 1 year and showed complete recovery from symptoms and not complaining of reflux disease.

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