A Case of Achalasia Cardia

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35 years old farmer, admitted to our hospital with history of difficulty in swallowing for the last 2 years which was progressive over the years along with regurgitation of food, which was both for the solid and liquids and pain in the retrosternal region. He had weight loss of around 10 kilograms in the last 2 years. There was no history of fever, cough, nasal regurgitation or throat pain. He had dysphagia severity of grade 5. He also noticed that these symptoms increased on lying down position and on taking large meals. He was a non smoker and an occasional alcoholic.

Clinically he had mild pallor and systemic examination was within normal limits. Blood parameters were within normal limits except haemoglobin which was 10.50 gm%. A plain chest X-ray (P-A view) was done which showed a double mediastinal stripe with absence of gastric bubble under left hemi diaphragm.

Fig. 1 : Chest X-ray PA view showing a large heterogeneous tubular opacity running longitudinally all across the chest suggestive of mega oesophagus and absence of gastric bubble under left hemi diaphragm

Fig. 2 : Barium swallow showing massively dilated tortuous oesophagus filled with barium and a smooth tapered narrowing of distal oesophagus, producing a “bird beak” appearance

Fig. 3 : Barium swallow image showing relaxation of gastro oesophageal junction with passage of barium into the stomach

There after a barium swallow study was preformed which revealed a dilated oesophagus more at the distal end and failure of peristalsis to clear the barium with tapering of barium column at the unrelaxed lower oesophageal sphincter, resulting in a “bird beak” appearance.

Manometry could not be performed as lack of facility in our hospital. Pneumatic dilatation was also not performed as this facility is also not available in our hospital and therefore patient was referred to the gastro surgeon for the surgery and he underwent a successful surgery with symptomatic improvement in the follow up.

Achalasia cardia is a rare (affecting one in one lakh subjects) motility disorder involving the smooth muscles layer of oesophagus and the lower oesophageal sphincter (LOS) characterised by incomplete lower sphincter relaxation, increased LOS tone and lack of peristalsis. It can be primary where the aetiology is unknown and secondary or pseudoachalasia where it results

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from gastric carcinoma infiltrating the oesophagus, lymphomas, Chagas disease and other infiltrative disorders. Its pathophysiology results in loss of inhibitory neurons in oesophageal myenteric plexus. Presenting complaints are dysphagia, regurgitation of food, chest pain and occasionally nocturnal coughs.

Preferred radiological examination is a barium swallow study done under fluoroscopic guidance and it should be confirmed by an upper gastrointestinal endoscopy and oesophageal manometry.

There are various modes of treatment with each modality having its strengths and weaknesses which make them each suitable to different populations. These can be pharmacological treatment aimed to relax the lower oesophageal sphincter like calcium channel blockers, isosorbide dinitrate or sildenafil. Injection of botulism toxins or endoscopic balloon dilatation are other therapeutic options aimed to reduce LOS and finally it can be corrected surgically by Hellers myotomy with fundoplication.

References