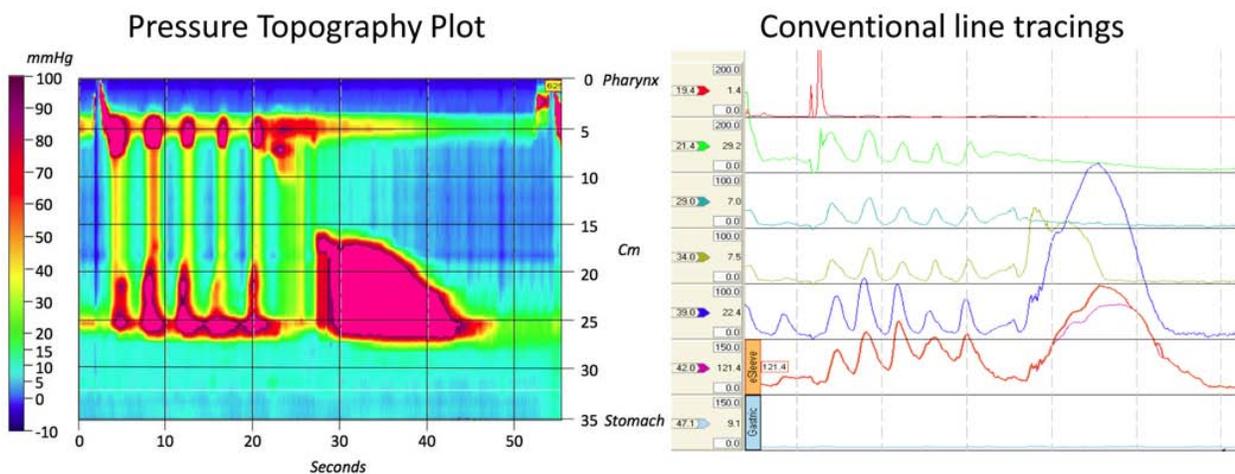


Question 39 – Week of May 6

A 44-year-old Hispanic gentleman presents to you with 3 years of intermittent dysphagia now followed by 2 weeks of persistent dysphagia to both solids and liquids. He's had a subtle amount of weight loss perhaps 5-10 pounds over the last year. With the intermittent dysphagia he denies a diet aphasia, cough or significant heartburn but does state that he tends to regurgitate small amounts of undigested food on occasions. He sometimes awakes with his symptoms. An upper endoscopy completed at an outside hospital was reported as normal. He was given a proton pump inhibitor to try and alleviate his symptoms and this was unhelpful. After securing the negative endoscopic report you to decide to proceed with a motility study. Both the high-definition and conventional line tracings are shown below.



This tracing is most consistent with the following diagnosis

- A. Classic achalasia
- B. Achalasia with esophageal pressurization
- C. Spastic achalasia
- D. Pseudo-achalasia
- E. Diffuse esophageal spasm

Answer: C

This high resolution manometry plot as well as the conventional line tracing demonstrate evidence of nonperistaltic repetitive high amplitude contractions in the esophagus and a poorly or non-relaxing lower esophageal sphincter. Classic achalasia is associated with an absence of peristalsis and no evidence of the repetitive high amplitude contractions noted in this study. Achalasia with esophageal pressurization is demonstrated by compression of the swallowed water boluses between the upper and the nonrelaxing GE junction. Again there would be a lack of repetitive high amplitude nonpropulsive contractions in the esophageal body. Pseudo-achalasia is ruled out by the negative upper endoscopy for a malignancy involving the cardia.

Finally, diffuse esophageal spasm although associated with similar high amplitude nonperistaltic contractions would not necessarily be associated with a nonrelaxing or poorly relaxing lower esophageal sphincter.

Reference:

Bansal, A. and Kahrilas etal. *Curr. Opin Gastroenterol* 26(4): 344-351, 2010.