Extremely High Panesophageal Pressurization in Type II Achalasia

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A 74-year-old man came to our motility clinic with a complaint of difficulty in swallowing solid food and liquid that had seriously progressed for the past 2 months. Two years ago, he developed intermittent swallowing difficulty but maintained usual daily life without serious problems. After then, the symptom abruptly progressed for the last 2 months before visit. He was not able to swallow anything for two days before coming to our clinic. Esophagastroscopy showed the very narrow and tight lower esophagus (Fig. 1A) and the tight esophagogastric junction constraining an endoscope strongly (Fig. 1B). Advancing an endoscope was difficult and even needed much force. Endoscopic ultrasonography demonstrated thickened esophageal inner circular muscle, approximately 2.5 mm, at 40 cm from upper incisor (Fig. 2A). High-resolution manometry revealed elevated mean integrated relaxation pressure of 21.8 mmHg with panesophageal pressurization in all ten swallows (Fig. 2B). The pressure of the esophageal body during swallowing was extremely high; elevated up to 150.0 mmHg at the lower esophagus (Fig. 2B). According

Figure 1. Endoscopic findings. (A) Esophagoscopy reveals a tightly narrowed distal esophagus at 40 cm from the upper incisor, even with full aeration. It was very hard to advance an endoscope through the lower third of the esophagus. (B) Retroflexion view shows that esophagogastric junction constricts an endoscope tightly (arrows).
to Chicago classification, this patient was categorized as achalasia type II due to elevated integrated relaxation pressure and panesophageal pressurization. The interesting point is amazingly high panesophageal pressurization represented by red color, 80 to 120 mmHg, and dark purple color, 150 mmHg (Fig. 2B). This dramatic high-resolution manometry finding can explain why the lumen of the lower esophagus was nearly collapsed, and why it was so hard to advance an endoscope through the lower esophagus, even more difficult than to pass esophagogastroduodenal junction. He underwent peroral endoscopic myotomy, 10 cm in length. Eckardt symptom score decreased to 3 from 5, and he could swallow soft and solid diet.

Reference