

Short Report

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Mini-invasive approach for end-stage achalasia

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Introduction

End-stage achalasia is characterized by a significant esophageal dilatation added to the presence of tortuosity with a clinical presentation of progressive malnutrition and, in general, with a failure in the traditional surgical myotomy [1,2]. The objective is to present a group of patients treated with megaesophagus due to end-stage achalasia.

Material and methods

In the period between March 2008 and December 2021, 7 patients were treated minimally invasively for presenting megaesophagus due to achalasia at the end of stage (Figure 1).

Of the total, 3 corresponded to the male sex and 4 to the female sex. The average age was 54.7 with a range of 35 to 66 years. One case corresponded to a megaesophagus of Chagasic origin, and the other 6 cases were due to recurrence of the Heller-Dor myotomy, which was treated with endoscopic dilations. The treatments performed were: 1 laparoscopic transhiatal esophagectomy and a minimally invasive esophagectomy in the prone position (Figure 2) 4 esophagus ardioplasty procedures, as described in Figure 3, and 1 case of resection of the esophago-gastric junction and Roux-en-Y bypass.



Figure 1: Esophagus barium swallow.



Figure 2: Megaesophagus.

Results

As postoperative complications, a case of pneumonia was recorded in the patient who underwent transhiatal esophagectomy. In cases where esophagus cardioplasty was performed, gastroesophageal reflux was notorious, but with significant relief of dysphagia and adequate weight recovery. The patient with Roux-en-Y bypass had a fistula as a complication that required reoperations for lavage and drainage. There was a loss of follow-up in the patient who underwent transhiatal esophagectomy and in another who underwent esophagus cardioplasty, the other patient who received this same treatment died at three years due to his chagasic cardiomyopathy. The other two patients continue with periodic controls.

Discussion

In the management of the final stage of achalasia, the strategy must be focused on the preservation of the organ. Recurring symptoms after surgical myotomy should be managed with endoscopic myotomy (POEM), re-Heller, or on-demand pneumatic dilations [1-4]. Before resection of the esophagus, there are some procedures such as esophagus cardioplasty, as presented in our series, which is a valid alternative to improve dysphagia, although it is highly questioned due to the significant reflux that it entails [5]. Recently in a publication by Ithurralde et al. an option is described that consists of esophageal transection and reconstruction through an intestinal loop with “Roux-en-Y” anastomosis; it seems to have very satisfactory results, so it could be considered an alternative treatment before esophagectomy [5]. Despite all these conservative therapeutic options, patients must be followed up rigorously to detect the need for an esophagectomy early. One of its predictive factors is massive dilatation of the organ (diameter greater than 6 cm) [7,8]. Therefore, esophagectomy continues to be a potential indication in patients with recurrent achalasia and radiological progression of the disease in the event of failure. of all minimally invasive treatments.

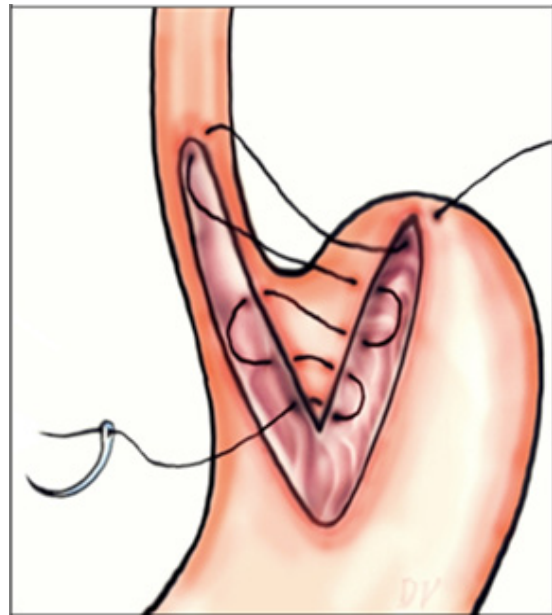


Figure 3: Esophagus cardioplasty.

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