



CASE REPORT: RETURN OF NORMAL ESOPHAGEAL PERISTALSIS FOLLOWING HELLER MYOTOMY FOR TYPE 2 ACHALASIA

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Introduction: The etiology of achalasia has yet to be confidently elucidated.

Introduction of high resolution manometry (HRM) has differentiated achalasia into three distinct types based on esophageal body motility pattern. Type 2 achalasia has been shown to have the highest response to treatment with a majority of patients having partial return of normal peristalsis. This is the first contribution to the literature in the era of HRM of a patient with type 2 achalasia having complete return to normal peristalsis post Heller myotomy.

Methods: A review of the literature was performed by searching PubMed for keywords and phrases: “achalasia”, “high resolution manometry”, “heller myotomy” “return of esophageal peristalsis”, and “return of esophageal function”.

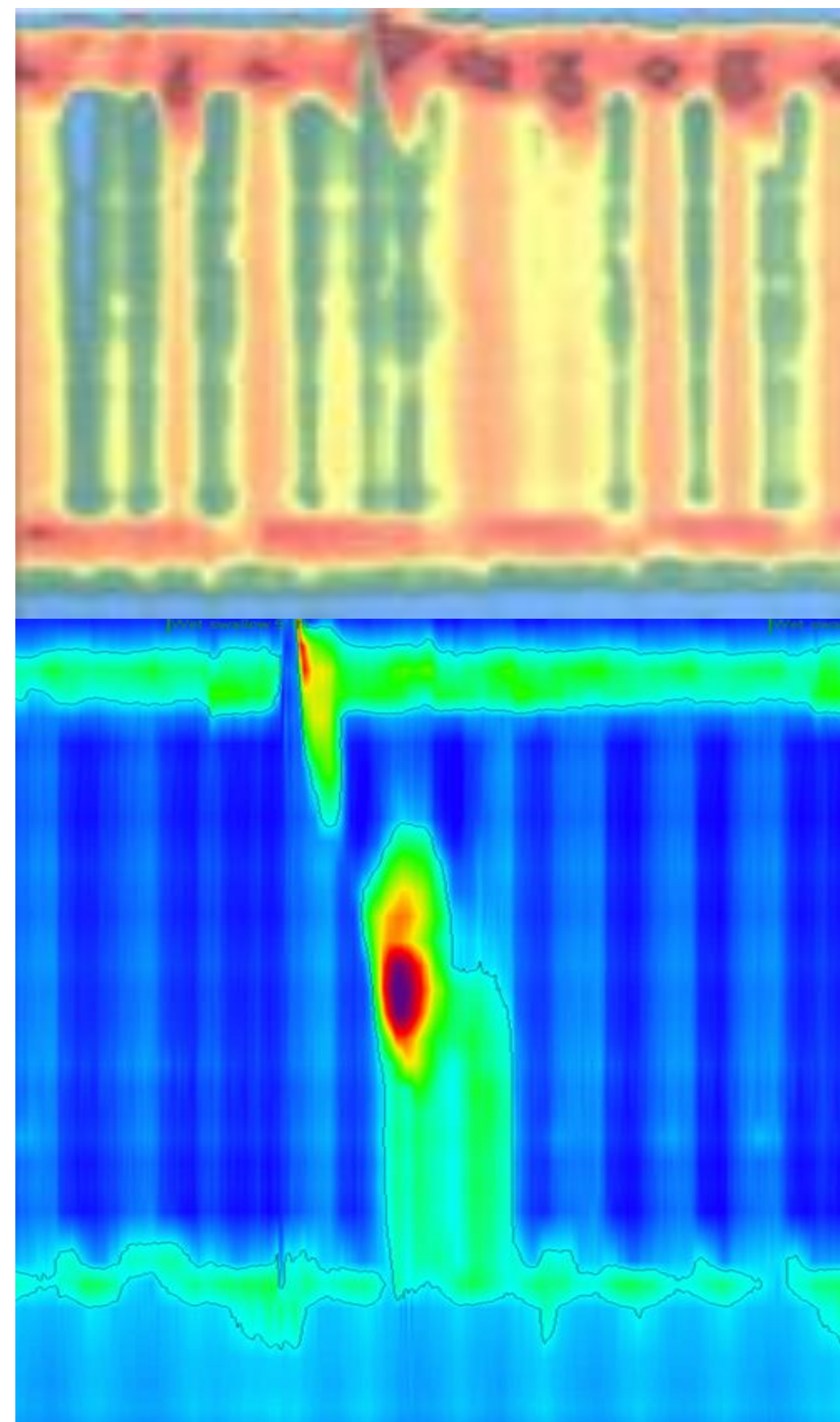


Figure 1: Manometry. Top: pre op. Bottom: Post op.

Case Report: A 36 year old male presented to clinic complaining of three years of progressive solid and liquid dysphagia, esophageal reflux, and sharp spasmodic chest pain. Eckardt score was 11. HRM revealed an integrated relaxation pressure (IRP) of 53mmHg and panesophageal pressurization with 0% peristalsis, consistent with type II achalasia. Upper endoscopy revealed a hypertensive lower esophageal sphincter (LES), and esophagram showed a dilated esophagus with classic “bird beak” narrowing at the LES. A laparoscopic Heller myotomy with Toupet fundoplication was performed. Postoperatively, the patient had complete clinical symptom resolution with an Eckardt score of 0 and return to a regular diet. Routinely performed 1 year postoperative repeat HRM revealed an IRP 13mmHg, distal contractile integral of 2138mmHg.s.cm, and 100% normal peristalsis.

Conclusion: This case adds to the ever growing body of evidence suggesting that esophageal body dysmotility seen in achalasia, especially in the type 2 variety, may be secondarily caused by the physiologic effects of the LES outflow obstruction. In this case, by mechanically relieving the primary LES outflow obstruction, the secondary upstream effects on esophageal motility were also resolved.