Management of Achalasia After Sleeve Gastrectomy

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Introduction

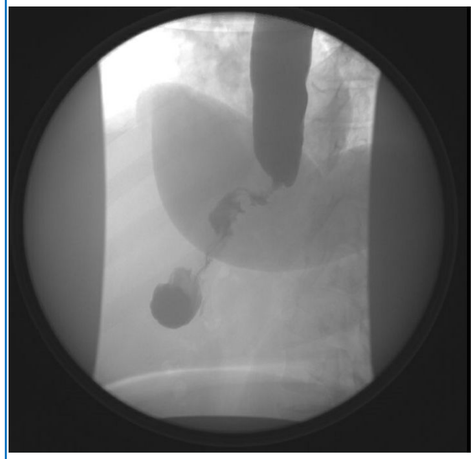
- Rare case of Type 1 achalasia diagnosed several years after sleeve gastrectomy
- Patient failed multiple types of conventional treatment including botox injections to lower esophageal sphincter and heller myotomy
- Ultimately required total gastrectomy with roux-en-y esophagojejunostomy

Clinical Presentation

- 54 year old female underwent laparoscopic sleeve gastrectomy 5 years prior at another institution
- Presented with GERD and dysphagia to both solids and liquids

- **Investigations:**

Barium swallow:



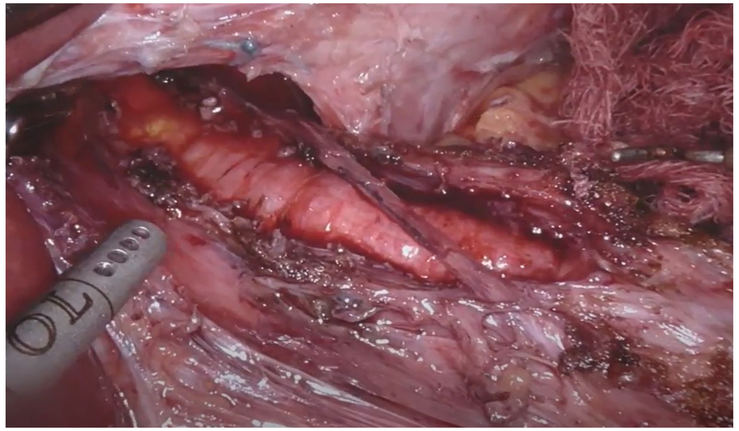
High Resolution Esophageal Manometry:

- Elevated integrated relaxation pressure
- Minimal lower esophageal sphincter relaxation
- No motility throughout esophagus

- **Management:**

Botox injection to LES: Failed to relieve symptoms

Robotic Assisted Laparoscopic Heller Myotomy:



- Adequately opened gastroesophageal junction, but had persistent dysphagia
- Follow up barium swallow showed dilated esophagus and slow transit through GEJ

Total gastrectomy, roux-en-y esophagojejunostomy:

- Resolved dysphagia - patient discharged tolerating full liquids

Discussion

- Achalasia after sleeve gastrectomy is a rare presentation but incidence likely to grow as bariatric surgery grows
- Heller myotomy has been successful in treating achalasia in patients with roux-en-y gastric bypass.[1]
- This patient's narrow gastric anatomy from previous sleeve gastrectomy may have prevented resolution of dysphagia after heller myotomy

CONCLUSIONS

- Traditional myotomy procedures for achalasia may not be beneficial in patients with previous sleeve gastrectomy

1. Aiolfi A, Tornese S, Bonitta G, Rausa E, Micheletto G, Bona D. Management of Esophageal Achalasia after Roux-en-Y Gastric Bypass: Narrative Review of the Literature. Obes Surg. 2019 May;29(5):1632-1637. doi: 10.1007/s11695-019-03774-y. PMID: 30778843