Laparoscopic Heller Myotomy for the Resolution of Achalasia in a Bariatric Patient: Case Report

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INTRODUCTION

Achalasia after bariatric surgery is a rare pathological entity. The cardinal symptoms include dysphagia, regurgitation, chest pain, and weight loss.

Pneumatic dilation, endoscopic myotomy, and laparoscopic Heller myotomy can provide lasting symptom relief.

OBJECTIVE

The objective is to present the case of the diagnostic and surgical approach in a patient diagnosed with achalasia, along with a review of the literature.

CASE PRESENTATION

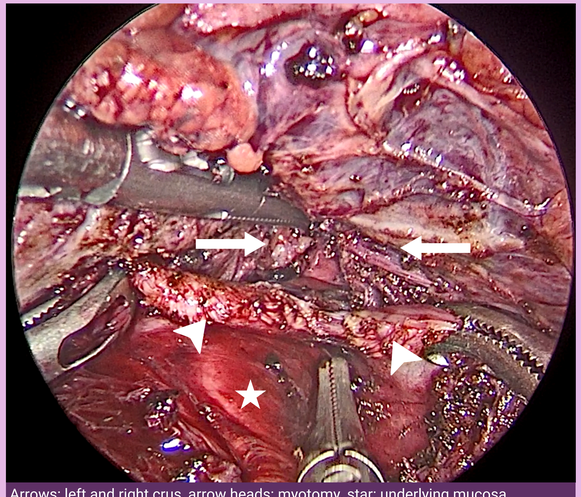
A 31-year-old male with a surgical history of placement and removal of a gastric band. He began his current condition five months before experiencing dysphagia to solids, which improved with the intake of proton pump inhibitors and prokinetics, accompanied by productive cough, and regurgitation.

A computed tomography identified a distended esophagus throughout its entire length and thickening in the distal third.

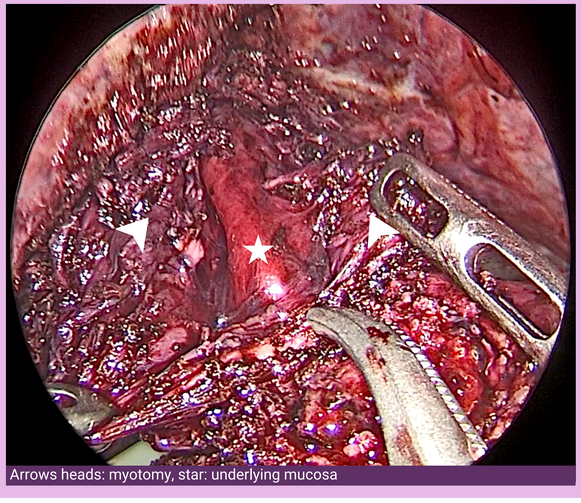
A panendoscopy was performed, revealing a 100% stenosis of the esophagus, preventing the passage of the endoscope.

An esophagogastroduodenal series showed a marked delay in the passage of contrast at the esophagogastric junction. Manometry confirmed a diagnosis of type II achalasia.

A laparoscopic Heller myotomy was decided upon. Many stomach adhesions to the wall were found and released.



Arrows: left and right crus, arrow heads: myotomy, star: underlying mucosa

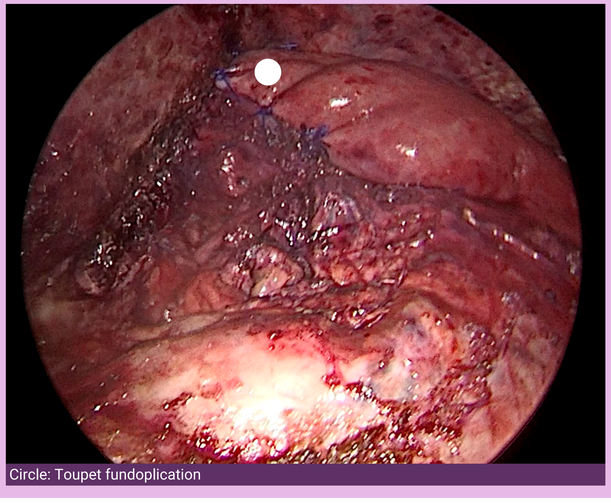


Arrows heads: myotomy, star: underlying mucosa

The right diaphragmatic pillar of the crus was located, and dissection of the esophageal hiatus was performed. The left side was then dissected. Next, the esophageal hiatus was dissected, followed by intraoperative endoscopy, showing the gastroesophageal junction with no ability to pass the endoscope due to stenosis at that level. Once the gastroesophageal junction was identified, the Heller myotomy was initiated with cautery. The myotomy was extended proximally for about 5 cm above the gastroesophageal junction and distally 4 cm onto the gastric wall. Adequate passage of the endoscope was verified. A plication of the pillars was performed, and a posterior Toupet fundoplication was then carried out.

Patient postoperative course went uneventful, and was discharged due to improvement.

Follow-up consultations were uneventful.



Circle: Toupet fundoplication

CONCLUSIONS

Achalasia after bariatric surgery is a rare pathological entity. However, several cases have been described in the literature. In patients with gastric bands, dysphagia symptoms typically resolve after deflation and removal of the band. However, there are case reports of persistent symptoms following the removal, as seen in our patient.

Laparoscopic Heller myotomy has excellent efficacy, with improvement in symptom scores in over 90% of patients and high satisfaction in more than 90% of cases up to 5 years after the procedure.

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