

ACHALASIA OF THE CARDIA

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ABSTRACT:

Achalasia of the cardia is an uncommon neuromuscular disorder originally described by Willis in 1972. Ernst Heller performed the 1st successful cardiomyotomy for this condition on 14th April, 1913 by performing only anterior myotomy. Zaaizer modification of Heller's procedure is most often performed today. The result of cardiomyotomy are generally satisfactory but patient might have persistent or recurrent difficulty in swallowing or develop new symptoms of reflex oesophagitis and stricture. We have case reports of two cases where this operation was performed without any of these complication so far.

CASE NO. 1:

20 years old male admitted to E.N.T. Ward of DHQ, Hospital, Abbottabad presented with five years' history of dysphagia which was of gradual onset. Physical examination was unremarkable and chest x-ray was normal. Ba swallow showed a dilated oesophagus with smooth narrowing of the lower end. No peristalsis was seen and diagnosis of achalasia was made. At oesophagoscopy there was dilation of oesophagus. But no mucosal lesion was seen, the case was referred to us in surgical "a" Unit. Nasogastric lube was attempted but failed and on second day of admission operation was performed. A left paramedian incision was made, oesophagus was mobilised for 10 cm and myotomy, (Heller) operation was done. She was started on fluid after 48 hours and had progressed to a regular feed by the time of discharge 8 days after operation.

CASE NO. 2:

12 years old girl was admitted to Pediatric Ward of Hospital with a history of dysphagia. It was gradual in onset but recently she had a difficulty in swallowing any solid. The physical examination, basic haematological investigations were unremarkable. Chest x-ray showed widening of mediastinum with fluid level present. Ba swallow examination with fluoroscopy demonstrated a dilated atonic oesophagus with a typical rat tail deformity at the lower end consistence with a diagnosis of achalasia. Oesophagoscopy showed dilated oesophagus but no lesion in the mucosa. She was referred to DHQ, Hospital Surgical "A" Unit and operated the next day. Left paramedian incision was made oesophagus was easy to mobilised for 10 cm and 7 cm oesophagogastric myotomy (Heller operation was done). She was started on fluid after 48 hours and on semisolid on 4th day and solid on 7th day and discharged on 9th day.

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DISCUSSION:

Achalasia usually present in adults of either sex between the age of 30 and 50. It can occur in children and even in infancy, of slow onset, the patient usually feels food sticking at the lower end of sternum and difficulty is more marked with solids than with fluids. At first dysphagia may be intermittent and is aggravated by swallowing cold food. If untreated food may be regurgitated and choking may be experienced at night, pulmonary complications result from aspiration of oesophagus contents and sometime chest trouble may be the presenting symptoms. Nutrition impaired and patient maybe week and may develop arthritis of rheumatocal type.

Diagnosis depends on history, x-rays examination and monomeric studies. X-ray of chest may show mediastinal shadow with air or fluid levels in the dilated oesophagus. Barium swallow demonstrates a fusiform dilation of oesophagus with gross dilation and haustrations —octrl nitrate or buscopan relaxes the sphincter while mechody¹ causes contraction for the gullet associated with pain.

Aim of treatment is to relieve the obstruction at the lower oesophageal sphincter and prevent oesophageal reflex. Drug treatment with use of nitrates and cholinergic agents has proved disappointing. Dilation has been used but improvement in short and oesophageal perforation is the main danger. The Heller's operation or lower oesophageal myotomy is commonly practiced. The lower oesophagus is approached through the upper abdominal incision or thoracotomy thorough 8th inter space. The lower 10 cm of oesophagus is mobilised and vagi are preserved. The circular muscles of the lower oesophagus are divided with care not to damage the mucosa. Section should extend over 7 cm and pass through the oesopagogastric junction in the stomach wall.

Achalasia of the cardia has been essential features, obstruction at the cardiac inlet and absence, peristalsis with dilation having of oesophagus. Depending on theories of origin obstruction may be referred to as cardiospasm, phrenospesm and more accurately achalasia. Histological studies show absence or marked decrease in number of ganglion cells in Aurbachs plexus with degeneration of preganglionic fibers. The cause of degeneration is unknown although infection, vitamins deficiency or vagal abnormality have all been incriminated because of absence of peristalsis, food accumulate in oesophagus which becomes dilated and atonic, it may be fusiform in shape but sometime assume a sigmoid curve. The intra-abdominal segment becomes elongated. The muscle wall hypertrophies and inflammatory changes occur in the Mucosa which may show leukoplakia and ulceration after several years' malignant change any supervene in the deleted segment in about 12% of cases.

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