

Computed tomography of type I esophageal achalasia

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CASE REPORT

A 62-year-old female presented to the emergency department (ED) complaining of a three week history of nausea, vomiting, and chest pain. She had a known history of achalasia and was treated with Botox injections of the lower esophageal sphincter six months prior to this encounter. She reported improvement of symptoms for only a short period of time following the Botox injections. In the ED, computed tomography of the chest revealed a markedly dilated esophagus containing a large amount of debris (arrow) consistent with achalasia (Figure 1) as well as pulmonary infiltrates likely due to aspiration

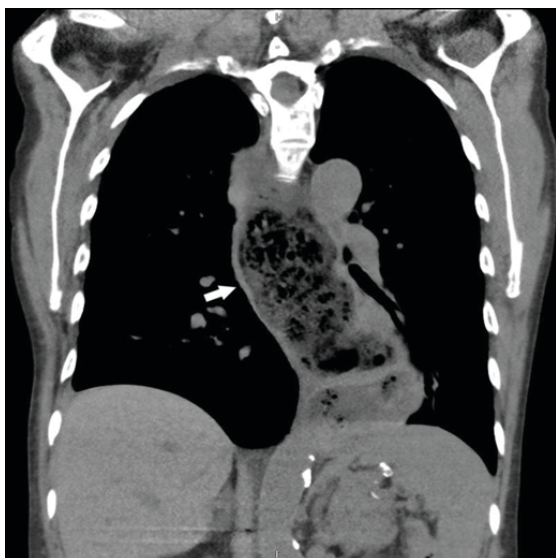


Figure 1: Coronal computed tomography of the chest showing marked dilation of the esophagus containing large amounts of food debris (arrow) consistent with achalasia.

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pneumonia. The patient was admitted to the internal medicine service in consultation with the gastroenterology service and an esophagogastroduodenoscopy (EGD) was scheduled to determine her suitability for an endoscopic versus surgical myotomy as definitive treatment. Ultimately, this patient's definitive treatment was a peroral endoscopic myotomy (POEM).

DISCUSSION

Achalasia is thought to be an autoimmune-related condition that results in spasticity of the lower esophageal sphincter resulting in substantial dilation of the esophagus and subsequent congestion of food debris. It is relatively rare with prevalence being approximately 10 diagnosed cases per 100,000 individuals. Symptomatology often includes dysphagia, thoracic chest pain, regurgitation, and consequent weight loss. Although it can be associated with a variety of disorders, etiology is often unknown or unclear [1]. Treatment is typically conservative initially, but often requires endoscopic or surgical myotomy [2]. Even though myotomy is considered a definitive treatment, patients should continue to be followed by a gastroenterology team for continued evaluation of effectiveness of swallowing as well as signs of esophageal erosion [3].

This case report details the presentation, treatment course, and impressive advanced imaging of a woman suffering from type I esophageal achalasia. The differential diagnosis for any patient presenting with painful dysphagia, weight loss, thoracic pain, aspiration pneumonia, or regurgitation should include esophageal achalasia. Computed tomography of the chest should be considered in such patients to evaluate any dilation of the esophagus as well as to potentially discover occult infiltrates if none were discovered with X-ray. Consultation with gastroenterology should be considered early in order to facilitate a definitive treatment plan promptly [4].

CONCLUSION

Achalasia is less likely to be considered for the differential diagnosis of patients with thoracic chest pain and dysphagia because it is rare. It is important, especially for generalist clinicians to keep this diagnosis in mind as

a possibility when designing and implementing a work up as timely diagnosis can prevent complications, such as aspiration, significant weight loss, and esophageal erosion.

Keywords: Achalasia, Computed tomography, Regurgitation, Thoracic chest pain

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Author Contributions

Joanna K Buitrago – Conception of the work, Design of the work, Acquisition of data, Analysis of data, Drafting the work, Revising the work critically for important intellectual content, Final approval of the version to be published, Agree to be accountable for all aspects of the

work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

Lauren M Schroeder – Conception of the work, Design of the work, Acquisition of data, Analysis of data, Drafting the work, Revising the work critically for important intellectual content, Final approval of the version to be published, Agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

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Conflict of Interest

Author declares no conflict of interest.

Data Availability

All relevant data are within the paper and its Supporting Information files.

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