

New diagnostic approach to diagnosis of achalasia after recent Chicago classification

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We read with great interest the recently published article by Müller [1]. The author aimed to explain the importance of high-resolution manometry (HRM) on achalasia diagnosis and management. She explained conventional manometry (CM) and HRM criteria for diagnosis of achalasia. We thank Muller for this valuable study, but we think that there are some controversies needed to be clarified.

First, the author mentioned that additional effort is needed for esophageal body motility evaluation by positioning of pressure sensors in the body, instead of evaluating when positioning on lower esophageal sphincter (LES). CM contains 4-8 pressure sensors. In order to assess the LES and the esophageal body in one investigation, it is better to use a catheter with 4 or more transducers in the esophagus. For example, with 8-sensor CM when the lower sensors (5th-8th) are on LES high-pressure zone, the other 4 sensors (1st-4th) are on the esophageal body 5, 10, 15, and 20 cm above of the LES. Thus, we think that these sensors are adequate to evaluate esophageal motility, especially in the lower two-thirds of esophageal body [2].

Second, the author also mentioned that for diagnosis of achalasia with HRM, mean integrated relaxation pressure (IRP) must be elevated from upper limit of normal (>15 mmHg). But recently, it has been indicated by the International HRM Working Group that it is better to use median IRP rather than mean IRP at the diagnosis of achalasia [3].

Third, the author clearly defined achalasia subgroups and esophagogastric junction (EGJ) outflow obstruction, but the importance of EGJ outflow obstruction should be analyzed in detail in this study [1]. EGJ outflow obstruction is described by an elevated median IRP with some instances of intact or weak peristalsis, which do not meet achalasia criteria. EGJ outflow obstruction may be an achalasia variant, but it also has several potential etiologies including esophageal stiffness as a consequence of an infiltrative disease or cancer, or of vascular obstruction of the distal esophagus [3]. Thus, patients with this diagnosis should be further evaluated by endoscopic ultrasound and CT to clarify the etiology of EGJ obstruction.

In conclusion, although CM still has its place in the diagnosis of achalasia, we think that the exact diagnosis of achalasia has to be done with HRM because of the importance of the diagnosis of EGJ outflow obstruction as described above.

References

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