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Image and Learning

An Interesting Case of Post-fundoplication Dysphagia

Mayank Jain

Department of Gastroenterology, Choithram Hospital and Research Center, Indore, India

A 40-year-old male patient, who had undergone laparoscopic fundoplication for hiatus hernia 2 years ago, presented with history of dysphagia for solids for 18 months and weight loss of 12 kg over last 18 months. The dysphagia was persistent, severe, affected by food intake and was associated with chest pain. He was prescribed proton pump inhibitors and underwent 2 sessions of esophageal dilatation up to 15 mm balloon but had no relief of symptoms. High-resolution manometry (Figure) revealed a high resting basal lower esophageal sphincter (LES) pressure (48 mmHg) with high mean integrated relaxation pressure (49.2 mmHg). Esophageal peristalsis was normal in 6/10 wet swallows and showed weak peristalsis with small/large breaks in 4/10 swallows. A sudden increase was noted in the LES pressure up to 300 mmHg after each wet swallow. A diagnosis of hypertensive LES with impaired esophagogastric junction relaxation was made.

Laparoscopic fundoplication is a commonly performed surgery. Common late post-operative complications include gas-bloat syndrome (up to 85%), dysphagia (10-50%), diarrhea (18-33%), and recurrent heartburn (10-62%).[1] Kahrilas et al[2] reported that fundoplication limits the axial mobility of the esophagogastric junction and causes restricted hiatal opening. Sato et al[3] reported a post-operative dysphagia rate of 6% and the main causes were inaccurate preoperative endoscopy, hiatal stenosis secondary to severe fibrotic reaction, anterior angulation of the gastroesophageal junction, missed diagnosis of the short esophagus, nutcracker esophagus and a too tight fundoplication. O'Brein et al[4] reported 2 cases of esophageal dysmotility which were not evaluated prior to surgery and had post-fundoplication dysphagia.

In this patient, severe post-operative dysphagia is probably linked to severe fibrosis and inadequate preoperative workup for

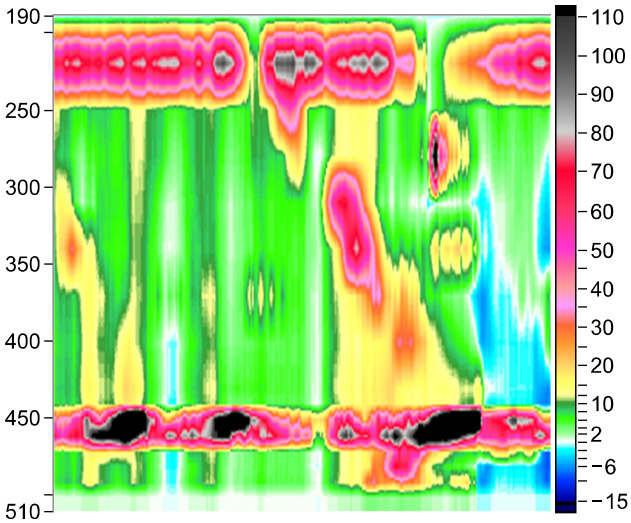

Figure. Manometric recording of the patient.

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*Correspondence: Mayank Jain, MD, DNB
Department of Gastroenterology, Choithram Hospital and Research Center, Manik Bagh, Indore 452014, India
Tel: +91-895-924-5040, E-mail: mayank4670@rediffmail.com
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ORCID: http://orcid.org/0000-0003-1176-5167.

dysmotility. The patient denies history of dysphagia for 6 months after surgery and so it appears unlikely to be due to a tight fundoplication. The patient has been advised dilatation using balloon and if there is insufficient relief, a revision surgery.

References

1. Richter JE. Gastroesophageal reflux disease treatment: side effects and complications of fundoplication. Clin Gastroenterol Hepatol 2013;11:465-471.
2. Kahrilas PJ, Lin S, Spiess AE, Brasseur JG, Joehl RJ, Manka M. Impact of fundoplication on bolus transit acrossesophagogastric junction. Am J Physiol 1998;275(6 Pt 1):G1386-G1393.
3. Sato K, Awad ZT, Filipi CJ, et al. Causes of long-term dysphagia after laparoscopic Nissen fundoplication. JSLS 2002;6:35-40.
4. O'Brien CJ, Collins JS, Collins BJ, McGuigan J. Aperistaltic oesophageal disorders unmasked by severe post-fundoplication dysphagia. Postgrad Med J 1991;66:1047-1049.