

Achalasia after Sleeve Gastrectomy: A Surgical Challenge

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Introduction

Achalasia is an esophageal motility disorder characterized by absence of esophageal peristalsis and failure of the lower esophageal sphincter (LES) to relax during swallowing [1]. Prevalence of achalasia in the general population is around 10 cases per 100,000 individuals [2]. Even when studies report a higher prevalence of esophageal motility disorders in obese patients compared to cohorts with normal body mass index, achalasia and morbid obesity are two conditions that do not classically occur together [3,4]. For this reason, there are no established surgical guidelines as to the treatment for patients who present with achalasia and morbid obesity. It is well known that Laparoscopic Heller Myotomy (LHM) and partial fundoplication is the standard surgical approach for achalasia in non-obese population [5].

There is also evidence that bariatric surgery is the most effective treatment for morbid obesity; being sleeve gastrectomy and Roux-en-Y gastric bypass (RYGB) the most frequently performed bariatric operations [6]. However, there is little information regarding how to treat achalasia after bariatric surgery. Cases of achalasia treatment after RYGB have been described in literature, but there is scarce information about treating achalasia after sleeve gastrectomy.

Case Report

We present the case of a 41-year-old female patient who presented to the emergency department with chief complaint of persistent dysphagia to solids and liquids. The patient had a history of morbid obesity and had undergone Laparoscopic Sleeve Gastrectomy (LSG) in 2018, at an outside institution. She reported having dysphagia to solids and liquids since her early twenties, but had not been evaluated previously for this complaint. Our patient also reported episodes of post-prandial nausea and vomiting with associated epigastric discomfort. She also had a surgical history of abdominoplasty and bilateral breast implants performed a few months after LSG. There were no significant findings on physical exam.

Preoperatively, contrast esophagogram demonstrated a standing column of oral contrast at the distal esophagus secondary to either a tight stenosis or beaking (Figure 1). An upper endoscopy was performed and revealed a dilated esophagus. The scope was advanced into the stomach without stricture or mucosal lesions identified. On manometry, elevated resting LES pressures were reported with absent relaxation during swallowing. It also revealed esophageal body aperistalsis with esophageal pressurization, consistent with Type 2 achalasia.

After the above findings, the patient was scheduled for Laparoscopic

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