Dysphagia but a normal OGD – what next?

Stuart Riley
Sheffield

Is it Dysphagia?

- prospective 12 month audit n=396
- 60 (15.2%) no swallowing problems
- only 29 (8.6%) new cancer diagnoses
- most had benign reflux related disease

Mellaney et al 2005

Causes of Dysphagia

Murray et al WJG 2012

Dont Forget Non-OG Malignancy

- ENT
- Bronchial
- Mediastinal
- Pancreatic

History

- Dysphagia is common
- Separating oesophageal and oropharyngeal dysphagia can difficult
- Ask about swallow sequence and hoarseness, coughing, choking, regurgitation
- Distinguish dysphagia from globus sensation
Examination

- Mouth, teeth, neck, lower cranials
- Abdomen
- Systemic disease
- Consequences

Other tests

- ?Repeat OGD
- CXR
- Barium (bread)
- CT scan
- Videofluoroscopy
- Oesophageal function tests

Oesophageal Dysmotility

- Achalasia
- Diffuse Oesophageal Spasm (DOS)
- Hypercontractile Oesophagus
- Absent or Weak Peristalsis

Standard Oesophageal Manometry

- Multiple sensors in close proximity
- Circumferential sensitivity
- Sophisticated plotting algorithms

Limitations of conventional manometry

- Poorly defined (achalasia and DOS)
- Abnormalities could be found in normals
- Poorly reproducible
- Limited correlation with symptoms
- Doesn’t reliably predict course of disease
- Technically demanding

High Resolution Manometry
Topographical and Contour Plots

Clouse and Staiano 1990s

HRM Normal Swallow

MII

Equipment
Achalasia

Traditional definition

- incomplete lower esophageal sphincter (LOS) relaxation
- absent peristalsis

Detecting Achalasia (IRP)

Table 1: Sensitivity of diagnostic & relaxation measures in detecting achalasia

<table>
<thead>
<tr>
<th>Relaxation Measure</th>
<th>Achalasia Sensitivity (%)</th>
<th>False Negative (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single sensor radii &lt;7 cm Hg</td>
<td>92</td>
<td>48</td>
</tr>
<tr>
<td>High-resolution radii &lt;15 mm Hg</td>
<td>60</td>
<td>28</td>
</tr>
<tr>
<td>Gastric integrated relaxation pressure &lt;15 mm Hg</td>
<td>97</td>
<td>3</td>
</tr>
</tbody>
</table>

Ghosh JK et al AJP 2007

Categorising Achalasia

Pandolfino et al GE 2008

Prognostic guide

- Type 1 56%
- Type 2 Botox 71% Balloon 91% Surgery 100%
- Type 3 29%


Impaired OGJ relaxation but preserved peristalsis

- ?incomplete expression of achalasia
- ?undetected mechanical cause
- Imaging important consider CT and or EUS
- Few have small HH ? crural
Spasm (DOS)

Weak Persitalsis

- Conventionally distal peristaltic amplitude >30mmHg at 3 and 8cm proximal to LOS
- New insights with HRM and MII HRIM
- 30mm too high cut off
- Critical breaks in 20mm or 30mmHg IBC
- Breaks > 5cm always associated with incomplete bolus transit
- Breaks 2-5cm variable bolus transit

HRM and MII = HRIM

Weak Peristalsis


Treatments

- Nitrates
- Calcium antagonists
- Phosphodiesterase inhibitors
- Botox
- Prokinetic agents
- Dilatation
- TCA/SSRI
Take aways

• Some don’t have swallowing difficulties
• Consider what may have been missed
• Remember non OG malignancy
• Consider neurological problems
• Trial of PPI
• HRIM beginning to make a difference
• Therapy for dysmotility still limited