

Pneumatic dilatation of achalasia in a patient with sigmoid esophagus

Sigmoid özofaguslu bir olguda akalazya balon dilatasyonu

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We report herein a method for pneumatic dilatation in a patient with achalasia complicated with sigmoid esophagus, since it could not be performed using the standard methods.

Keywords: Pneumatic dilatation, sigmoid esophagus, achalasia

Achalasia is a primary motility disorder of the esophagus characterized by incomplete relaxation of the lower esophageal sphincter (LES) and aperistalsis of the esophagus. Pneumatic dilatation and surgical myotomy are effective methods for treatment (1). Pneumatic dilatation may be difficult via standard methods in patients complicated with sigmoid esophagus.

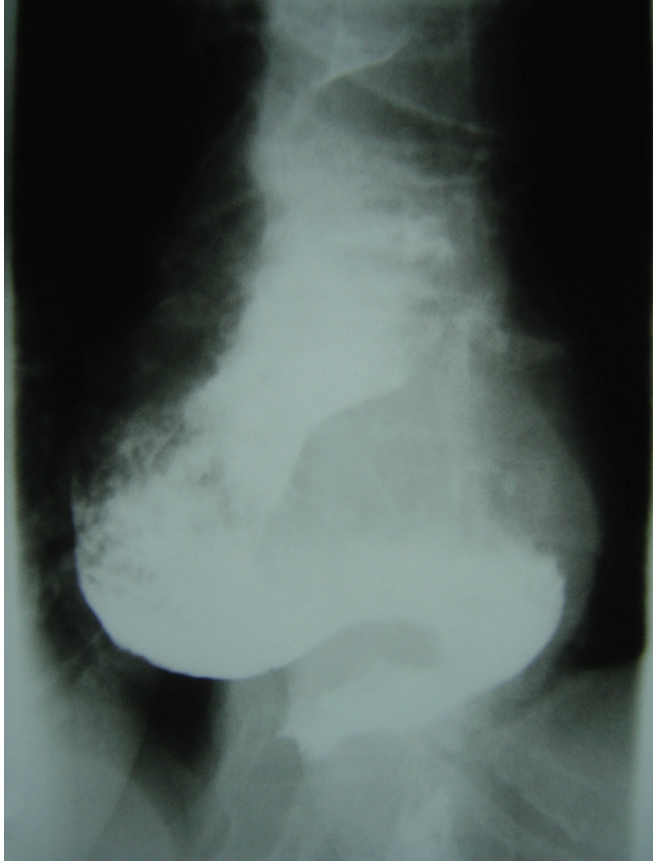


Figure 1. Barium esophagography shows extremely dilated and tortuous esophagus and irregular filling defects secondary to food residues.

Bu yazıda, sigmoid özofagus gelişimi ile komplike olmuş akalazyalı bir hastada, standart yöntemle balon dilatasyonu yapılamadığı için kullandığımız bir yöntemi bildiriyoruz.

Anahtar kelimeler: Balon dilatasyonu, sigmoid özofagus, akalazya

An 83-year-old woman was admitted with complaints of dysphagia and postprandial vomiting. The esophagus was detected as tortuous and dilated on barium esophagography, which was described as sigmoid esophagus (Figure 1). The esophageal lumen was extremely wide and tortuous and contained food residues on endoscopic examination. The endoscope was forwarded with difficulty to the distal part of the esophagus, and the LES level could only be passed with some difficulty. The stomach and duodenum were normal. A gu-

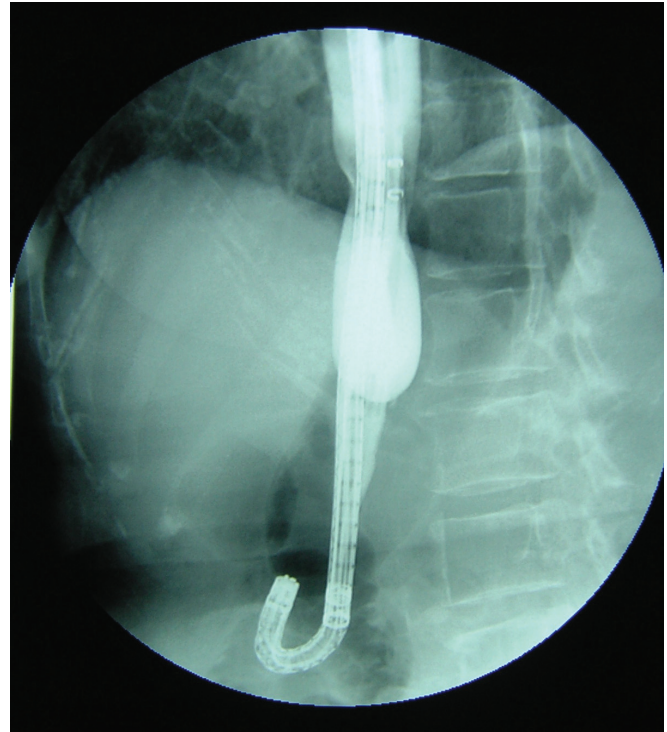


Figure 2. Fluoroscopic image shows the dilatation procedure while the balloon is attached to the endoscope. The endoscope is in the retroflex position and the balloon is seen at the LES level.

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idewire was left in the stomach; however, the attempt to pass a 30 mm balloon over the wire was not possible because of the extremely tortuous and dilated esophagus. In the next step, a balloon was attached to the endoscope with plaster and both were passed into the stomach successfully. Pneumatic dilatation was performed with endoscopic and scopic guidance, after the balloon reached the mid-LES level, which was observed endoscopically in the retroflex position (Figure 2). Endoscopic control was possible in the same process, and no complications were observed except mucosal hemorrhage.

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Different methods have been reported previously for pneumatic dilatation in patients with sigmoid esophagus. Holloway and McCallum (2) attached the pneumatic dilator with internal stiffener to the guidewire, while Bernstein and Barkin (3) used an overtube, and Kerr et al. (4) attached the pneumatic dilator to an endoscope using a string.

In conclusion, in patients with sigmoid esophagus, the pneumatic dilator can be attached to the endoscope, and dilatation can be performed more easily and safely with endoscopic and fluoroscopic guidance.