

Treatment of Achalasia: Lets put surgery in its right context

Madam, We read with interest the report of Ahmed et al in which they described the medical and surgical management of achalasia in 46 patients over a five-year period from their specialist units of a research centre and teaching hospital.¹ The authors have made a significant effort to provide an addition to the local literature. However, we were disappointed to read the conclusions. The impression given in their conclusion in favour of pneumatic dilatation for the treatment of achalasia is biased, unscientific and misleading.

The authors have not provided any robust scientific evidence in their study to support their conclusions. The success rate of pneumatic dilatation is 81% in comparison with 80% following surgical myotomy. Their patient groups are only very broadly defined and the study lacks detail regarding pre-operative status and operative technique. Reference is made to subjective assessment at 4 weeks and 6 months with repeat endoscopic treatment or referral to surgeons but lacks detail and the overall duration of follow up or use of objective assessments of 'clinical success' are absent. Even allowing for the limitations of a retrospective study the conclusions remain only very general. They are unsupported by statistical comparison between what may very well be heterogenous groups. Questions remain: who benefits in the unit, for how long and by how much?

Moreover, in their discussion they have neglected recent advancements showing a significantly improved result using Laparoscopic Heller Myotomy (LHM). This is reflected by the fact that their most contemporary reference concerning pneumatic dilatation originates from 2005 yet not a single paper regarding the outcome of surgical intervention

from recent literature is cited, reflecting a bias in favour of medical management of achalasia.

Achalasia remains a condition with an incompletely understood pathogenesis. Treatment approaches are largely palliative and aim to achieve relaxation or dilatation of the lower oesophagus. Admittedly, clear dominance of one approach has not been established even in large trials. There is recognition that multiple treatment modalities over an extended period of time may be required.² It is additionally recognised that certain sub-groups - particularly the frail elderly - may benefit from the less invasive endoscopic approach with botulinum toxin injection, although the benefit remains short-lived.³ Modern surgical management has progressed to recognition of a new gold-standard surgical approach — that of the Laparoscopic Heller Myotomy. This is frequently combined with fundoplication, although controversy remains regarding the degree of fundal wrapping and the optimal myotomy length.⁴ No explicit reference is made to such techniques. Additionally, prior endoscopic dilatation has been demonstrated to worsen subsequent surgical outcome, a fact of which patients should be aware in an informed decision making process.⁵

Several studies have shown surgical myotomy to provide superior long term symptoms relief as compared with non-surgical intervention. Structured, objectively assessed reports yield impressive short-term results. A cohort of 113 patients undergoing LHM declared 91.2% to be symptom-free at median follow up 2 years,⁶ a result in keeping with much of the contemporary literature. The focus of current studies is to refine the technique, comparing the influence of

extended and standard myotomies, and varying degrees of fundal wrap.⁴ Additionally, as a treatment in evolution, long-term data is now emerging supporting the sustained efficacy of LHM. A 10-year follow-up study has recently reported longevity of the improvement in dysphagia scores obtained following LHM in comparison to those determined in the short term (17 patients, comparing outcomes at mean 27 months and 11.2 years).⁷

In their study, 2 out of 32 patients developed perforation after pneumatic dilatation, whereas 20 patients underwent surgery had uneventful recovery and did not develop any serious complication. Even then authors conclude that pneumatic dilatation is a safe procedure whereas no safety benefit is mentioned in favour of surgical intervention.

We recognise the importance of disseminating experience between centres. However, we have significant concerns regarding their conclusions both in the context of the presented data and its relevance to the contemporary surgical management of this condition.

Clinical literature is largely self-regulating. A critical eye is always required when transferring the experiences of others to one's own practice. Readers must be cautious if

modifying their practice on the basis of this report.

MH Shiwani, CG Whitfield,

Department of Surgery,
Honorary Senior Clinical Lecturer, University of Sheffield, UK.
Barnsley Hospital NHS Foundation Trust, Barnsley, UK.

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