

ESOPHAGEAL DISORDERS

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..... Symptoms

Heartburn, dysphagia, and odynophagia almost always indicate a primary esophageal disorder.

A. Heartburn

Heartburn (pyrosis) is the feeling of substernal burning, often radiating to the neck. Caused by the reflux of acidic (or, rarely, alkaline) material into the esophagus, it is highly specific for GERD.

B. Dysphagia

Difficulties in swallowing may arise from problems in transferring the food bolus from the oropharynx to the upper esophagus (oropharyngeal dysphagia) or from impaired transport of the bolus through the body of the esophagus (esophageal dysphagia). The history usually leads to the correct diagnosis.

1. Oropharyngeal dysphagia-The oropharyngeal phase of swallowing is a complex process requiring elevation of the tongue, closure of the nasopharynx, relaxation of the upper esophageal sphincter, closure of the airway, and pharyngeal peristalsis. A variety of mechanical and neuromuscular conditions can disrupt this process (Table 15-8).

Problems with the oral phase of swallowing cause drooling or spillage of food from the mouth, inability to chew or initiate swallowing, or dry mouth. Pharyngeal dysphagia is characterized by an immediate sense of the bolus catching in the neck, the need to swallow repeatedly to clear food from the pharynx, or coughing or choking during meals. There may be associated dysphonia, dysarthria, or other neurologic symptoms.

2. Esophageal dysphagia-Esophageal dysphagia may be caused by mechanical obstructions of the esophagus or by motility disorders. Mechanical obstruction experience dysphagia, primarily for solids. This is recurrent, predictable, and, if the lesion progresses, will worsen as the lumen narrows. Patients with motility disorders have dysphagia for both solids and liquids. It is episodic, unpredictable, and can be progressive.

C. Odynophagia

Odynophagia is sharp substernal pain on swallowing that may limit oral intake. It usually reflects severe erosive disease. It is most commonly associated with infectious

esophagitis due to Candida, herpesviruses, or CMV, especially in immunocompromised patients. It may also be caused by corrosive injury due to caustic ingestions and by pill-induced ulcers.

..... Diagnostic Studies

A. Upper Endoscopy

Endoscopy is the study of choice for evaluating persistent heartburn, dysphagia, odynophagia, and structural abnormalities detected on barium esophagography. In addition to direct visualization, it allows biopsy of mucosal abnormalities and of normal mucosa (to evaluate for eosinophilic esophagitis) as well as dilation of strictures.

B. Videoesophagography

Oropharyngeal dysphagia is best evaluated with rapid sequence videoesophagography.

C. Barium Esophagography

Patients with esophageal dysphagia often are evaluated first with a radiographic barium study to differentiate between mechanical lesions and motility disorders, providing important information about the latter in particular. In patients with esophageal dysphagia and a suspected motility disorder, barium esophagoscopy should be obtained first. In patients in whom there is a high suspicion of a mechanical lesion, many clinicians will proceed first to endoscopic evaluation because it better identifies mucosa lesions (eg, erosions) and permits mucosal biopsy and dilation. However, barium study is more sensitive for detecting subtle esophageal narrowing due to rings, achalasia, and proximal esophageal lesions.

D. Esophageal Manometry

Esophageal motility may be assessed using manometric techniques. They are indicated: (1) to determine the location of the LES to allow precise placement of a conventional electrode pH probe; (2) to establish the etiology of dysphagia in patients in whom a mechanical obstruction cannot be found, especially if a diagnosis of achalasia is suspected by endoscopy or barium study; (3) for the preoperative assessment of patients being considered for antireflux surgery to exclude an alternative diagnosis (eg, achalasia) or possibly to assess peristaltic function in the esophageal body. High-resolution manometry may be superior to conventional manometry for distinguishing motility disorders.

E. Esophageal pH Recording and Impedance Testing

The pH within the esophageal lumen may be monitored continuously for 24-48 hours. There are two kinds of systems in use: catheter-based and wireless. Traditional systems use a long transnasal catheter that is connected directly to the recording

device. Wireless systems are increasingly used; in these systems, a capsule is attached directly to the esophageal mucosa under endoscopic visualization and data are transmitted by radiotelemetry to the recording device. The recording provides information about the amount of esophageal acid reflux and the temporal correlations between symptoms and reflux.

Esophageal pH monitoring devices provide information about the amount of esophageal acid reflux but not non acid reflux. Techniques using combined pH and multichannel intraluminal impedance allow assessment of acid and nonacid liquid reflux. They may be useful in evaluation of patients with atypical reflux symptoms or persistent symptoms despite therapy with proton pump inhibitors to diagnose hypersensitivity, functional symptoms, and symptoms caused by nonacid reflux.

TABLES

Table 1 5-8. Causes of oropharyngeal dysphagia.

Neurologic disorders

Brain stem cerebrovascular accident, mass lesion

Amyotrophic lateral sclerosis, multiple sclerosis, pseudobulbar palsy, post-polio syndrome, Guillain-Barre syndrome

Parkinson disease, Huntington disease, dementia

Tardive dyskinesia

Muscular and rheumatologic disorders

Myopathies, polymyositis

Oculopharyngeal dystrophy

Sjogren syndrome

Metabolic disorders

Thyrotoxicosis, amyloidosis, Cushing disease, Wilson disease

Medication side effects: anticholinergics, phenothiazines

Infectious disease

Polio, diphtheria, botulism, Lyme disease, syphilis, mucositis (Candida, herpes)

Structural disorders

Zenker diverticulum

Cervical osteophytes, cricopharyngeal bar, proximal esophageal webs

Oropharyngeal tumors

Postsurgical or radiation changes

Pill-induced injury

Motility disorders

Upper esophageal sphincter dysfunction

Table 1 5-9. Causes of esophageal dysphagia.

Cause

Mechanical obstruction

Schatzki ring

Peptic stricture

Esophageal cancer

Eosinophilic esophagitis

Motility disorder

Achalasia

Diffuse esophageal spasm

Scleroderma

Ineffective esophageal motility

Clues

Solid foods worse than liquids

Intermittent dysphagia; not progressive

Chronic heartburn; progressive dysphagia

Progressive dysphagia; age over 50 years

Young adults; small-caliber lumen, proximal stricture, corrugated rings, or white papules

Solid and liquid foods

Progressive dysphagia

Intermittent; not progressive; may have chest pain

Chronic heartburn; Raynaud phenomenon

Intermittent; not progressive; commonly associated with GERD