The “swinging” squamocolumnar junction in esophagocardiac achalasia

A 45-year-old woman was referred for evaluation of longstanding dysphagia to both solids and fluids, and progressive regurgitation over the past 10 years. Besides glycojenic acanthosis, upper gastrointestinal endoscopy was suggestive of esophageal dilation with a hypotomital contraction pattern. During careful observation with air insufflation, the narrowed esophagogastric junction failed to relax but could be passed easily, giving rise to a popping sensation (Fig. 1). Likewise, on retroflexion the cardia appeared tight, with discrete tongues extending from the squamocolumnar junction (Fig. 2). To better assess the endoscopic characteristics of the presumed achalasic cardia, we carried out a thorough dynamic retroflexed examination with different levels of scope insertion. In contrast with the close-up view, the esophagogastric junction sleeve flattened while advancing the esophagus in a 45-year-old woman with long-standing dysphagia and progressive regurgitation showing a narrowed esophagogastric junction.

Endoscopic view of the distal esophagus in a 45-year-old woman with long-standing dysphagia and progressive regurgitation showing a narrowed esophagogastric junction.

The diagnosis of esophagocardiac achalasia was established by manometry, which confirmed resting lower esophageal sphincter (LES) hypertension >60 mmHg with lack of swallow-induced relaxation and low-amplitude simultaneous esophageal body contractions. The patient subsequently underwent uncomplicated pneumatic balloon dilation (30 mm Rigiflex II Single Use Achalasia Balloon Dilator; Boston Scientific, Ratingen, Germany). Given that current practice trends in most countries prioritize upper gastrointestinal endoscopy in the diagnostic algorithm for patients with presumed esophageal dysphagia, the endoscopist should be aware of features suggestive of achalasia so as to avoid misdiagnosis, e.g., with strictures of peptic origin [1]. The clinical significance of endoscopy in achalasia is largely to rule out malignant pseudo-achalasia [2]. Despite endoscopy being negative in an estimated 40%–50% with less advanced or atypical motor disease, positive recognition of endoscopic achalasia characteristics is essential in stratifying patients for dedicated diagnostic work-up and treatment decisions [3]. The identification of potential novel endoscopic markers of esophagocardiac achalasia, such as the as-yet unreported phenomenon of the “swinging” squamocolumnar junction, most likely reflecting resting LES hypertension, might be helpful in timely referral for specialized motility testing. However, the diagnostic accuracy of this endoscopic finding and its correlation with manometric findings warrants further assessment in systematic studies, e.g., by blinded videotape review.

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V. Zimmer, F. Lammert
Department of Medicine II, Saarland University Medical Center, Homburg, Germany

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Corresponding author
Dr. V. Zimmer
Department of Medicine II
Saarland University Medical Center
Kirrberger Str. 100
66421 Homburg
Germany
Fax: 0049-6841-1623264
vincent.zimmer@uks.eu

Video 1
The squamocolumnar junction swinging in and out of endoscopic view on repetitive “to-and-fro” scope maneuvers.