

Curative Patient-Specific Approach of Achalasia


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Opinion

Achalasia is a chronic disease and all current treatments are in the palliative setting, focusing on decreasing the outflow resistance of the esophagogastric junction [1]. This relatively rare disorder is due to primary motor dysfunction, characterized by the absence of relaxations of the Lower Esophageal Sphincter (LES) and peristalsis along the esophagus [1]. Up to 50% of patients with achalasia experience heartburn, dysphagia, and weight loss. Regurgitation of food causes hoarseness and pneumonia. The exact etiology of this condition is unknown; however viral, autoimmune triggers, and neurodegenerative diseases are often afflicted to its presentation [2]. The incidence of achalasia varies between 2 to 3/100,000 inhabitants/year and increases with age, regardless of gender or race [3-8]. Sporadic idiopathic achalasia is the most common form and occurs secondary to the destruction of the myenteric plexus that coordinates the contraction and relaxations of LES [9-12]. In patients with achalasia barium esophagram and upper gastrointestinal endoscopy are mainly performed to rule out the presence of cancer and candidiasis. High-Resolution Manometry (HRM) is the gold standard for the diagnosis of esophageal motility disorders. HRM provides functional imaging of the esophagus and after the analysis according to the Chicago classification, a hierarchical categorization of motility disorders is made. This classification is also used for treatment outcome prediction. Some studies have shown that type II achalasia is an initial phase with pan-esophageal pressurization, while type I is a later phase with the complete absence of any contraction. And type III, characterized by premature spastic contractions, may represent a different pathological process [2]. Management of achalasia is aimed at reducing the pressure of the LES by using botulinum toxin injection or myotomy of the LES muscle [13-16]. Laparoscopic Heller Myotomy (LHM) has been the gold standard therapy [2,17-19]. The technique consists of an 8cm myotomy extending for 2.5cm onto the gastric wall and a Dor fundoplication [2]. Some prefer anterior fundoplication, with limited hiatal dissection, while a partial posterior fundoplication may keep the edges of the myotomy separated, decreasing the probability of recurrent symptoms. Peroral endoscopic myotomy, the method introduced in Japan, is performed by creating a long submucosal tunnel, followed by transection of the circular fibers for about 8cm-6cm on the esophagus and 2cm onto the gastric wall [2]. The results of a prospective European multicenter randomized trial have shown that compared to a 3-month follow-up, the rate of reflux esophagitis of 20% following LHM and 57% after POEM [2]. Some centers perform LHM for patients with type I and type II achalasia; as these patients have a hiatal hernia related to being overweight and the additional fundoplication for controlling the reflux. In patients with type III achalasia, POEM is considered the initial management. Pneumatic Dilatation (PD) is recommended in case of failure. If PD fails, it is advised to perform POEM and LHM for those following POEM [2]. As this chronic complex condition has multiple pathological pathways a holistic patient-specific treatment may be the cure. The pathological consequence is the degeneration of ganglionic cells in the myenteric plexus and the case degenerative process loss of inhibitory neurotransmitters, nitrous oxides,

and vasoactive intestinal peptides, and the imbalance between the excitatory and inhibitory neurons. The result is an unopposed cholinergic activity that leads to incomplete relaxation of LES and reduced peristalsis due to loss of gradient along the esophagus [20]. The concepts of the body's constitution and life forces are the basics of Ayurvedic (knowledge of life) treatment. Including purification, increasing resistance to disease, and harmony in life. According to Ayurveda, the disease is due to stress, and with certain lifestyle interventions and natural therapies, it regains a balance between the body, mind, spirit, and the environment [20]. Movement of the food in the intestine and defecation are a function of "VATA" in Ayurveda. A spasm is considered of disturbance of "VATA". This approach considers the basic "DOSHA" responsible for the symptom and planning treatment at the specific "DOSHA" causing the symptoms. Some treatments that can be offered: are hingvadibati increasing peristalsis, Erandataila release spasm, and Avipattikarachurna purgative. This approach offers a cure if more intensive clinical trials are performed with similar cases to further prove its efficacy. In some countries, evidence-based advice is not possible due to the lack of expertise or the involved costs. Modern research can be used to improve the Ayurvedic clinical practice. And a novel Ayurvedic approach can save time and costs by giving relief to clinical symptoms compared with intensive interventions proposed by modern medicine [20]. In conclusion, the approach for patients with achalasia should be patient-specific and holistic to gain the best patient outcome with fewer costs. For that part, it is important to include different-minded professionals concerning the definition and healing of the disease.

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