Dear Editor,

We describe a case report of a 58-year-old male patient who suffered from progressive dysphagia for liquids and solids. He had a past medical history of high-grade transitional urothelial carcinoma of the right renal pelvis diagnosed three years before. A nephrectomy was performed. In the resected specimen there was infiltration of the pelvic fat, without involvement of the surgical margins. One month after the intervention retroperitoneal lymphadenopathies were detected by routine computed tomography, and they were further confirmed by SPECT. He received four cycles of gemcitabine and cisplatin. After a good radiological response, the treatment was completed with external radiotherapy and he came into remission.

Three years later he developed progressive dysphagia for solids and liquids with a 4 kg loss of weight. He had also suffered from several episodes of vomiting and esophageal food stop. Upper endoscopy was normal. Esophageal manometry was consistent with classic achalasia. Due to a high index of suspicion of secondary achalasia we decided to continue the study. Abdominal CT demonstrated an unspecific thickening of the pillars of the diaphragm. EUS revealed marked and suspicious thickening of the pillars of the diaphragm together with signs of peritoneal carcinomatosis. A EUS-guided fine needle aspiration was done at that time. The tissue sample was diagnostic of recurrent urothelial carcinoma. Enteral tube feeding combined with a second-line chemotherapy was later started. After the second cycle of treatment his symptoms significantly improved.

Discussion

Secondary achalasia or pseudoachalasia is a rare esophageal motor disorder accounting for 2-4% of all cases initially diagnosed of primary achalasia (1). The clinical, radiological and manometric findings are usually indistinguishable from the primary disorder. The most common cause of this condition are malignancies arising in the gastro-esophageal junction, but there are described a wide variety of origins (2-5). Postoperative complications from the distal oesophagus or proximal stomach are also included as possible benign causes (6). The potential pathophysiological mechanisms are: direct infiltration and destruction.
of the inhibitory neurons of the myenteric plexus and interaction of tumor substances with the esophageal neural plexus without evidence of infiltration (paraneoplastic).

Some authors have suggested various clinical criteria that may raise the suspicion of pseudoachalasia: Older patients, short duration of symptoms and significant weight loss. In those cases it should be considered a more extensive evaluation looking for a secondary cause of the esophageal disease (6). Upper EUS has been described as a valuable tool in selected cases (7). In classic achalasia, the characteristic EUS finding is a slight thickening of the muscularis propria in the distal oesophagus. In pseudoachalasia, this thickening usually becomes longer than in the primary motor disorder. EUS is able to detect submucosal abnormalities and/or lymph nodes along with other lesions suspicious for malignancy not accessible by other techniques (8). In addition it will allow us to obtain tissue samples and make a definite diagnosis. It will consequently change the therapeutic approach and the prognosis in some cases. This is the first report of pseudoachalasia secondary to an urotelial neoplasia. A new location affected by tumor infiltration in this disorder is also reported, because infiltration of the pillars of the diaphragm has never been previously described.

Iago Rodríguez-Lago1, Susana de-la-Riva1,
José Carlos Subtil1, Marfa Dolores Lozano2,
José María López-Picazo1 and Miguel Muñoz-Navas1

1Gastroenterology Department. Endoscopy Unit. 2Department of Pathology. 3Department of Medical Oncology. Clínica Universidad de Navarra. Pamplona, Navarra. Spain

References