PWE-060

HIGH-RESOLUTION MANOMETRY ALTERS THE DIAGNOSIS IN PATIENTS DIAGNOSED WITH DIFFUSE OESOPHAGEAL SPASM BY CONVENTIONAL MANOMETRY: RESURGENCE OF ACHALASIA CARDIA

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Introduction Oesophageal manometry is the gold standard for the diagnosis of oesophageal dysmotility, a common clinical problem. Advances in manometric techniques by high-resolution manometry (HRM) and oesophageal pressure topography have revolutionised the interpretation of oesophageal physiology. There are reports of the impact of HRM to a change in manometric diagnosis.

Aim To study the change in the diagnosis of diffuse oesophageal spasm by HRM and its impact on clinical management of oesophageal dysmotility.

Patients and methods Between 2009 and 2010, all patients with a diagnosis of diffuse oesophageal spasm on conventional manometry referred for endoscopic botulinum toxin treatment were offered HRM at a tertiary referral centre. Case notes review was done for clinical symptoms at presentation, initial and final manometric diagnosis and outcomes of treatment.

Results 10 patients were referred for botulinum toxin treatment of diffuse oesophageal spasm. Presenting symptoms were dysphagia, chest pain, regurgitation and weight loss; 6 patients had more than one symptom. Mean age = 57.6 years with M: F = 1:2. Mean duration between onset of symptoms and referral to specialist service was 20.6 months. All had a normal gastroduodenoscopy. Seven patients had barium swallow showing: hiatus hernia (n=1), oesophageal dysmotility (n=3), probable achalasia (n=2) and normal study (n=1). On conventional manometry, 7 were diagnosed as diffuse oesophageal spasm (DES), 2 were diagnosed with hypertensive oesophageal contractions and one had diffuse dysmotility. Five of these patients had HRM at a tertiary centre. Three patients had features of classic achalasia, one revealed DES and one had functional oesophago-gastric junction (OGJ) obstruction. The patients with achalasia were treated with 100 units of Botulinum toxin injection at the OG junction. 2 of them had complete symptom resolution

and remained symptom free at 1 year follow-up. 1 patient with achalasia did not respond and was referred for a laparoscopic cardiomyotomy. Of the 5 patients with DES and hypertensive contractions 2 were treated successfully with Botulinum toxin injection to the OG junction and in the lower body of oesophagus. 3 patients had calcium channel blocker therapy with good symptom resolution.

Conclusion HRM alters the diagnosis of diffuse oesophageal spasm on conventional manometry to achalasia in a third of patients, and therefore has a significant impact on their treatment options. Based on this initial observation, a larger prospective study is planned to investigate this change to diagnosis.

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Keywords Botulinum toxin, Diffuse oesophageal spasm, High resolution manometry.