Correspondence

Forceful dilatation and oesophagomyotomy in patients with achalasia

SIR,—We were interested to read the further report by Csendes and his colleagues on the comparison of oesophagomyotomy and forceful dilatation for achalasia,[1] but believe it would be regrettable if their conclusions that 'surgical treatment offers better results than forceful dilatation with the Mosher bag' led others to believe that all dilatation treatment of achalasia is inferior to cardiomyotomy. We strongly believe that their comparison has been inappropriate because of their use of a dilatation technique which appears unsatisfactory. It was criticised[2] when described in their earlier report[3] but unfortunately there are still several reservations: (1) There is no mention of radiological evidence of full dilatation of the bag, so presumably this was not achieved in every case. (2) The pressure exerted '5·4 pounds per square inch' is rather low and unlikely to be effective; we use 20 pounds per square inch. (3) The duration of balloon inflation under pressure is probably too short to be beneficial. We find that full dilatation may take up to 20 seconds to be reached; our practice is then to keep the balloon fully inflated under pressure for 60 seconds. Other groups use comparable duration and pressure in their dilatations.[4] (4) The use of atropine may relax the sphincter, making the dilatation less efficacious. (5) It was distressing to read that patients experienced pain and discomfort during the procedure which had to be cut short. This probably did not allow full dilatation to take place making the comparison with the surgical group invalid. Our patients receive 10–20 mg Diazemuls and 50–100 pethidine intravenously which offer amnesia and alleviation of pain.

We have used several balloon dilators in the past, but we have recently been most satisfied with the 30 mm Rigiflex dilator which is designed in a similar way to the Grunzig angioplasty catheter.[5] Using this balloon in 23 patients in the last two years we have had no perforation and blood streaks were seen only in two cases without any significant bleeding; this is in contrast with 100% record of blood observed in the Santiago paper. It is premature to report on longterm results of our series but at annual follow up the success rate remains above 90%.

We think that forceful dilatation in experienced hands is still an effective and safe first line choice of treatment for all patients with achalasia, and would undoubtedly be the choice for the elderly patient. Patients who fail to respond to forceful dilatation can still be offered cardiomyotomy.[3,6,7]

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Reply

SIR,—I am deeply grateful to Drs M Dakkak and John Bennett for their interesting comments. My answers to their questions are the following: (1) All dilatations are done under fluoroscopic control. Therefore, we checked the correct placement of the back and the full dilatation of it. (2) There must be some printing errors because we use between 12 to 15 pounds per square inch, which is the measure of the Mosher back. (3) We have not been able to keep the balloon inflated for 60 seconds because patients very quickly experience pain and discomfort. We have not used diazemuls or pethidine intravenously because they could mask perforations in patients who do not feel pain. (4) The use of 0·5 mg atropine does not relax the sphincter in this patient as we have shown in an unpublished study. (5) Our results can only be applied to the Mosher back. Therefore, we know clearly that there are several types of balloons and probably some of them give better results. Only a late follow up of a prospective randomised study such as ours could solve the question concerning which is the best treatment in patients with achalasia. We should add that surgery in patients with failed dilatation is significantly more difficult and dangerous.

We are very happy that our study has provoked such controversy as only with cooperative and careful