ACG Guidelines: Diagnosis and Management of Achalasia

Goal: Review the work-up and treatment of achalasia

Who to suspect?

- Patients presenting with progressive dysphagia to solids and liquids, heart burn, chest pain, regurgitation, and weight loss or nutritional deficiencies.
- Patients diagnosed with GERD who are unresponsive to acid-suppressive therapy.

What test to order?

- Endoscopy to look for foam or puckering of the EGJ
- Barium esophagogram to look for retained barium or the classic “bird beaking”
- High resolution esophageal manometry (HRM)

Endoscopy  Barium esophagogram  HRM

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Citation: Vaezi MF, Pandolfino JE, Yadlapati RH, Greer KB, Kavitt RT. ACG Clinical Guidelines: Diagnosis and Management of Achalasia. Am J Gastroenterol. 2020 Sep;115(9):1393-1411. doi: 10.14309/ajg.0000000000000731. PMID: 32773454.
What classification criteria to use once the diagnosis of achalasia is made?

- Chicago classification for achalasia subtypes
  - Achalasia I – aperistalsis + panesophageal pressurization < 30 mm Hg
  - Achalasia II – aperistalsis + panesophageal pressurization > 30 mm Hg
  - Achalasia III – spastic contractions

- Classification help to inform prognosis and treatment

### Definitive Treatment

- Pneumatic Dilation (PD)
- Laparoscopic Heller Myotomy (LHM)
- POEM

### Symptomatic Treatment

- Botulinum toxin
- Pharmacologic

- Type I and II Achalasia
  - PD, LHM, or POEM

- Type III Achalasia
  - POEM

- Botulinum toxin for those who cannot undergo PD, LHM, or POEM

- Pharmacological treatment for those who cannot undergo definitive treatment and failed botulinum toxin
  - Calcium channel blockers
  - Nitrates
  - Anticholinergics
  - Beta-adrenergic agonists
  - Theophylline
  - Sildenafil
• If patients failed any initial definitive treatment, can use the other two definitive treatments.
  • Ex: PD is an appropriate therapy for retreatment post initial myotomy or POEM.
• In patients with megaesophagus or “end-stage achalasia,” can consider esophagectomy if other interventions have failed.
• Stent placement is currently not recommended for management of long-term dysphagia.
• Myotomy with fundoplication > myotomy without fundoplication in controlling distal esophageal acid exposure.

**Post Therapy Assessment**

• Do not obtain routine gastrograffin esophagram after dilation.
• Timed barium esophagram is first-line for continued or recurrent symptoms after definitive therapy.

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**Flowchart:**

- Symptoms of dysphagia ± chest pain and bland regurgitation
  - GERD symptoms not responsive to PPI therapy

  - **Upper Endoscopy**
    - Mechanical Obstruction/Esophagitis: Treat appropriately.
    - Normal
      - High Resolution Manometry, Timed Barium Esophagram (PHP may be helpful in patients unable to tolerate HRM)

  - **Type I or II Achalasia**
    - Definitive Therapy:
      - Pneumatic Dilatation [30/35/40 mm]
        - May start with 35 mm in young males
        - Routine gastrograffin is not needed
        - Repeat at 2-4 weeks if no response
      - Laparoscopic Heller Myotomy
        - Recommend Dor or Toupet fundoplication
      - POEM
        - Standard myotomy length
        - All patients discharged with PPI therapy
    - **Type III Achalasia**
      - Definitive Therapy
        - Tailored myotomy via POEM or tailored Heller myotomy

- Patients unfit for definitive therapy:
  - Botulinum toxin
  - Smooth muscle relaxants