

Case report

Achalasia, Misdiagnosed As Pulmonary Tuberculosis

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Introduction :

Achalasia is a primary motor disorder of esophagus characterized by insufficient lower esophageal sphincter (LES) relaxation and the defect also involves the lower two third of the esophageal body that result in aperistalsis (1), achalasia characterized radiologically by aperistalsis, esophageal dilatation, minimal LES opening with a (bird-beak) appearance ,and poor esophageal emptying of barium.(1)&(2) Esophagomanometry establishes the diagnosis showing esophageal aperistalsis and insufficient LES relaxation. The patient should undergo upper endoscopy to exclude pseudoachalasia arising from a tumor at the gastroesophageal junction (3). Achalasia is of unknown etiology, suggesting hereditary, degenerative, autoimmune and infectious (1,2). The disease affects both sexes in equal numbers and can occur at any age. The onset is usually in the third to fifth decade and fewer than 5% of patients have symptoms before adolescence.(4)

Most achalasia patients are symptomatic for many years before seeking medical attention. The most common symptoms are dysphagia for solids and liquids, (which is the predominant one), regurgitation and chest pain (3). About 60% of achalasia patients may have some degree of weight loss(5). Pulmonary symptoms indicate aspiration of esophageal content, 30% of patients reported nocturnal coughing spells, and nearly 10% had significant broncho-pulmonary complications(6) The risk of developing carcinoma in patient with achalasia appears to be higher than the general

population ,it predisposes to squamous carcinoma of the esophagus(7) which is estimated from Sweden study to be 16folds.these cancer rarely occur before fifteen years of symptoms, there are insufficient data to support routine endoscopic surveillance for these patients(8).

Case presentation :

H.A. A 45years old male, a worker presented with dysphagia for solid & liquid food of 15 years, associated with regurgitation & vomiting, The patient did not accept to do endoscopy when it was asked during that period. Two years ago he developed cough not associated with fever or haemoptysis, CXR was done at that time (fig.1), diagnosed as pulmonary tuberculosis, he was put on full antituberculosis. (INH, Rifadin, Pyrizin, ETB), all for two years.

The patient was referred to the GIT center for his gastrointestinal symptoms. He was re-evaluated & re-investigated. Barium swallow, CXR and endoscopy were done. The Barium swallow showed hugely dilated esophagus occupying most of the right lung with tapered lower esophageal end Fig 2 Endoscopy was revealed hugely dilated esophagus filled with a large amount of food particles and spastic lower esophageal sphincter. The CXR interpreted as hugely dilated esophagus filled with food particles, overlying the highly resembling pulmonary tuberculosis, which was changed after nasogastric aspiration of the esophagus Fig 3.

Endoscopy was repeated twice after aspiration with nasogastric tube and showed no mass, neither in the esophagus nor in the cardia.

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Endoscopic dilatation was difficult so the patient was referred for surgery. We had lost the follow up of the patient then. His investigation showed Hb:10mg\dl, ESR: 70mm\hr, Blood Urea: 20mg\dl, normal liver function test. Normal ultrasound& his barium study as shown in the fig.2.

Discussion:



Fig 1b

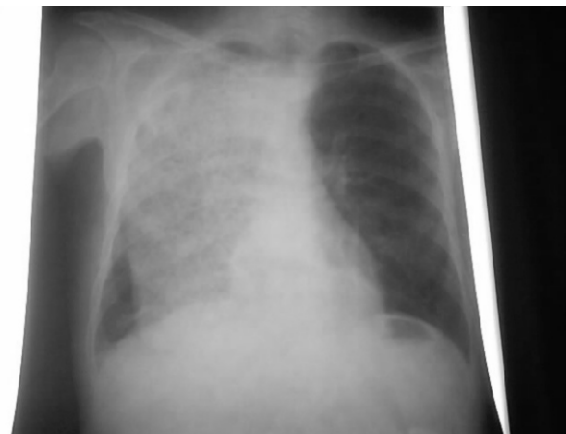


Fig 1a



Fig 2a

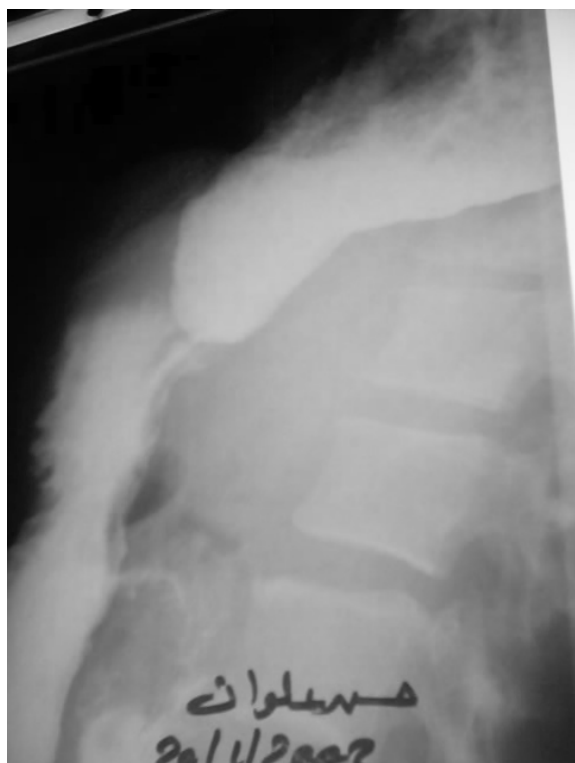


Fig 2b



Fig 3

Discussion:

Most patients with achalasia are symptomatic for years before seeking medical advice. The most common symptoms are dysphagia for solids & liquids, regurgitation, and chest pain. This contrast with patients having strictures or ring whose dysphagia is limited to solids. A chest radiograph may be abnormal in late disease, with a widening of the mediastinum from gross esophageal dilation and features of pulmonary aspiration.(9)

The patient was misdiagnosed as pulmonary TB due to the hugely dilated esophagus, filled with food particles overlying the right lung field as right pulmonary opacities giving impression of pulmonary tuberculosis, this differential diagnosis was not mentioned in the literatures.

The frequent delay in the diagnosis is not due to atypical clinical presentation of this disease but rather to misinterpretation of the typical clinical findings by physician consulted.(10)

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