

A 48-Year-Old Male With Dysphagia: What Is Your Diagnosis by High-Resolution Manometry Finding?

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A 48-year-old male visited to the department of gastroenterology for the evaluation of dysphagia for both liquid and solid foods for 3 months. A high-resolution manometry (HRM,

version 2.1, Manoscan, Sierra Scientific Instruments Inc., Los Angeles, CA) was performed. The mean integrated relaxation pressure was 27.5 mmHg and the mean intrabolus pressure was

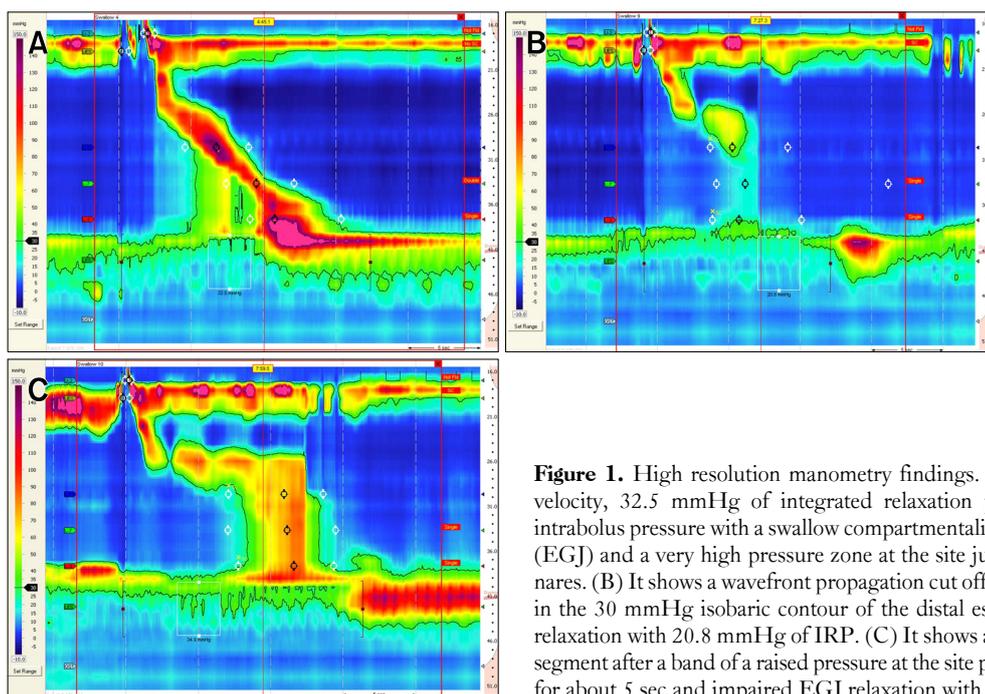


Figure 1. High resolution manometry findings. (A) It shows normal contractile front velocity, 32.5 mmHg of integrated relaxation pressure (IRP) and 38.5 mmHg of intrabolus pressure with a swallow compartmentalized above the esophagogastric junction (EGJ) and a very high pressure zone at the site just proximal to the 31 cm site from the nares. (B) It shows a wavefront propagation cut off at the 31 cm site, with a ≥ 3 cm defect in the 30 mmHg isobaric contour of the distal esophageal segment and impaired EGJ relaxation with 20.8 mmHg of IRP. (C) It shows a diffuse spasm of the distal esophageal segment after a band of a raised pressure at the site proximal to the 31 cm site from the nares for about 5 sec and impaired EGJ relaxation with 34.9 mmHg of IRP.

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22.6 mmHg in 10 swallows of 5 mL. According to the classification of individual swallows based on pressure topography criteria, 7 swallows were categorized into elevated intrabolus pressure (Fig. 1A), 2 swallows into hypotensive peristalsis (Fig. 1B) and the rest one swallow into spasm (Fig. 1C). What is your diagnosis by the HRM findings?

The HRM of 10 swallows is classified into functional esophago-gastric junction obstruction based on the Chicago classification of distal esophageal motility disorders. In addition, at the site just proximal to the 31 cm site from the nares, a very high pressure zone up to 140 mmHg (Fig. 1A) and the cutoff of peristalses (Fig. 1B and 1C) accompanied with upward displacement of the proximal end of the distal esophageal segment pressure and loss of the pressure transitional zone between the proximal and distal esophageal segments. Esophagoscopy revealed a circumferential ulcerative mass with marked luminal narrowing at the 31

cm to the 36 cm site from the incisor and the microscopic finding of biopsy revealed poorly differentiated squamous cell carcinoma. Esophagography showed mid esophageal luminal narrowing with abnormal proximal esophageal dilatation and delayed intermittent contrast passage to the distal esophagus. In conclusion, the present HRM findings are consistent with functional esophago-gastric junction obstruction and a partial mechanical obstruction of the mid esophagus.

Reference

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