

LETTER TO THE EDITOR

Dilation in achalasia – is normal distensibility enough:
Author's reply

We thank the author for his interest in our manuscript in which we evaluated the association between Esophagogastric Junction Distensibility (EGJ) distensibility and clinical outcome after pneumatic balloon dilation (PD) in newly diagnosed achalasia patients.^{1,2} We agree that intra-procedure assessment of EGJ distensibility with either the EndoFLIP or EsoFLIP could potentially increase the likelihood of a successful outcome in achalasia patients.³ However, reference values need to be defined before this technique can be applied in routine clinical practice. A recent systematic review demonstrated a large variability in EGJ distensibility, especially for healthy controls. This is presumably due to use of variable EndoFLIP balloons and different distension protocols.⁴

Besides the large variability in healthy controls, contrasting results have been described with regard to EGJ distensibility in achalasia patients after treatment.^{1,5,6} Teitelbaum *et al.* described that post-treatment EGJ distensibility in the range of 4.5–8.5 mm²/mmHg was associated with optimal symptomatic outcome in patients treated with peroral esophageal myotomy and laparoscopic Heller myotomy.⁶ Aside from the wide range of this 'optimal' post-treatment EGJ distensibility, it is important to note that the type of achalasia treatment might influence post-treatment EGJ distensibility.⁶ We hypothesize that post-treatment EGJ distensibility might be higher after surgical treatment compared to PD, although repeated PD might potentially have an additive effect compared to single PD.

Based on current available literature, it is therefore not possible to define a clear target for post-treatment EGJ distensibility in achalasia patients. O'Dea suggests

that the target should be a more distensible EGJ instead of an EGJ distensibility in the normal range.² Although achalasia was traditionally characterized by (i) insufficient lower esophageal sphincter relaxation and (ii) absent esophageal peristalsis, Pandolfino *et al.* found evidence for different achalasia subtypes based on manometric criteria.⁷ In addition, Carlson *et al.* detected esophageal contractility in the majority of untreated achalasia patients (i.e., 27% type I, 65% type II, and all type III patients) and studies found evidence for (partial) return of esophageal peristalsis after surgical treatment.^{8,9} In our opinion, it is therefore questionable whether the treatment goal in achalasia patients should be a higher than normal EGJ distensibility as treatment improves both EGJ obstruction and esophageal peristalsis. Although the EndoFLIP has the potential to guide treatment in achalasia patients, additional research is necessary to define adequate intra-procedure and post-treatment targets for EGJ distensibility to improve clinical outcome.

CONFLICTS OF INTEREST

No competing interests declared.

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