A picture or a thousand words: Routine timed barium esophagram after myotomy

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Central Message

Results from timed barium esophagram were associated with outcomes after myotomy and the need for reintervention but should be considered in combination with manometry findings and patient symptoms.

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In this issue of the *Journal*, Kachala and colleagues¹ describe the potential value of routine timed barium esophagram (TBE) after myotomy for achalasia and found that height and width measurements were associated with outcomes and the need for reintervention. Others have reported similar findings, including a 40% risk of failure with a <50% improvement in height at 1 minute,^{2,3} and Rohof and colleagues⁴ also proposed using TBE instead of manometry to decide on reintervention. A picture is worth a thousand words.

The authors recommend considering reintervention with worsening symptoms or worsening TBE. Does this mean that reintervention should be considered even in the absence of symptoms? They hypothesize that quantifying emptying objectively would be more reliable. Although symptoms do not always correlate with esophageal emptying,⁵ the presence of persistent or recurrent symptoms remains important in considering the balance between the risks and benefits of reintervention. Symptom improvement (decrease in the Eckardt score to less than 3) is also an important factor in determining success.⁶ The authors did not present data on patient symptoms and whether symptoms improved after initial treatment and reintervention. Does improvement in TBE correlate with improvement in symptoms?

With growing use of the Chicago classification, it is becoming increasingly recognized that achalasia is not one homogeneous disorder and that outcomes after intervention depend on the specific type (I-III) of achalasia.⁷ Although the authors have previously described the correlation of TBE with different achalasia subtypes,⁸ they do not describe in the current study how to interpret their TBE findings within these achalasia subgroups and whether the measurements associated with success or risk of reintervention need to be adjusted based on the specific subtype.

As the authors point out, many factors affect esophageal emptying, including the degree of esophageal dilatation and sigmoidal shape. However, most interventions for achalasia focus on palliating incomplete relaxation of the lower

esophageal sphincter. Would it be better to use studies focusing on the lower esophageal sphincter, such as high-resolution manometry or EndoFLIP (endoluminal functional lumen imaging probe)? Although TBE may serve as a screening study for ineffective esophageal emptying, it is important to confirm incomplete relaxation of the lower esophageal sphincter before considering surgical reintervention.

Although the authors have demonstrated the potential value of routine follow-up TBE, one limitation of the study is that TBE was used in clinical decision-making in determining whether patients underwent reintervention, a primary outcome of the study. Further studies are needed to delineate how TBE should be used within each achalasia subtype to optimize patient selection and to evaluate outcomes after peroral endoscopic myotomy.⁹ Is routine follow-up TBE better than simply getting a high-resolution manometry in symptomatic patients? Will treating asymptomatic patients with a high likelihood of recurrent symptoms help prevent progression to end-stage achalasia and avoid the need for esophagectomy? Until more data are available, it remains important to consider both the picture (TBE) and the thousand words (patient symptoms) along with manometry results in selecting patients for reintervention.

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